



The MODERN HOSPITAL

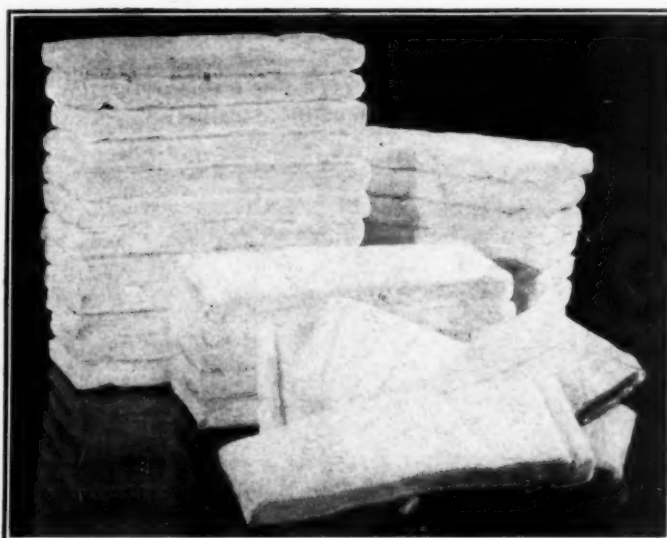
Vol. XXX,

June, 1928

No. 6

Published monthly at 660 Cass Street, Chicago, Ill., by The Modern Hospital Publishing Co., Inc. Entered as second-class matter October 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879. Copyright, 1928, by THE MODERN HOSPITAL PUBLISHING CO., Inc. Subscription—United States, \$3.00; Canada, \$3.50; Foreign, \$4.00.

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXX

June, 1928

No. 6

Why the Hospital Needs Sound Accounting Methods

By ALBERT E. SAWYER

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THE fact that hospitals do not ordinarily realize a profit seems to be an excuse for the lack of emphasis upon the business side of these institutions. Careful accounting seems to find a place only when it is necessary to protect the margin between cost and selling price that spells commercial success.

The fallacy of this situation is slowly dawning, and there is evidence that tends to show that there is an even greater need for scientific business system when there is no margin of profit to protect, but in its place a sacred obligation to spend with great care and foresight the community's contributions to its unfortunates. People have a right to begrudge what they spend for hospitalization. It is, in fact, an economic loss, and it is the grave concern of hospital administrators to keep this economic loss at a minimum. It is, at least, reasonable to ask that they exercise as much care in dispensing community funds as does a corporation manager in discharging his obligations to produce a profit.

Judged from this angle, it seems that the hospital administrator spending charitable funds has a much higher responsibility and a much greater obligation to use due care than the executive of an industrial plant intrusted with the profitable investment of the stockholders' money.

If a sound business organization and a thoroughgoing accounting system constitute due care in the case of the profitmaker, they most certainly enter into the dispensation of public charity.

In order to appreciate fully the function of a

business system organized to assist in the economical operation of a hospital, it is necessary first to redefine the purpose and objects of such a system. Contrary to current impression, the prime function of an accounting system is not the development of a historical record of financial transactions. While it is commendable to be able to point with pride to volumes of records, dating back to the organization of the institution, they alone are cold dead things, interesting, but lacking the vital power that radiates from a system used as the basis of current analysis of daily progress.

Analysis of any kind requires some systematic medium by which the vital factors can be segregated, subdivided, isolated, and then carefully synthesized into a comprehensive picture.

First let us consider the mechanics of expense analysis. For what purpose is money spent? How much is spent for nursing, dietetics, heat, light and power? Here we have a functional analysis. Where is money spent? How much in this ward, how much in that kitchen? Here we have a geographical subdivision. What do we buy? How much meat, coal, groceries? Here we have a classification of expense by commodities and services.

It is easy to realize the importance of a definite system in such an analysis. Hopeless confusion is inevitable without the aid of some scientific medium of analysis. The Business Office Association of Middle Western Universities, in its report on uniform classification, May, 1917, offers a practical suggestion in this direction. It is merely one of many methods, but will serve to illustrate

GROUP I GENERAL EXPENSE			GROUP II CARE OF PATIENT IN WARD AND ROOM			GROUP III SPECIAL OR CLINICAL CARE		
ADMINISTRATION 100	PHYSICAL PLANT 200	STORES 300	DIETETICS 400	HOUSEKEEPING 500	NURSING 600	GENERAL 700	CLINICAL 800	LABORATORIES 900
Executive Office 101 Business Office 102 Post Office 103 Tele. Operators 104 Research Bldg. 175	Main Bldg. 200 Central 250 Maternity 255 Contagious 260 South Dept. 270 Research 275 Nurses Res. 280 Miscel. Res. 290	Storeroom 301	General 401 Salad 403 Nurses Cafeteria 404 Commercial Cafetr. 405 Kitchen 410 Main Kitchen 411 Staff & Interns 412 Main Diet 422 2 East 423 3 East 424 4 East 425 2 West 432 3 West 433 4 West 434 2 Center 442 3 Center 443 4 Center 444 Private 445 Convalescent 450 Maternity 455 Contagious 460 South Department 470 Research Bldg. 475	General 501 Main Bldg. 502 Housekeeping 503 Linen Room 504 Housekeeping 552 Linen Room 553 Maternity 554 Contagious 555 South Dept. 570 Research Bldg. 575 Nurses Homes 580 Miscel. Homes 590	General 601 Clothes Room 602 Operating Rm. 604 Orth. Appliance Rm. 605 Surgical Supplies 606 Admitting Room 607 2 East 622 3 East 623 4 East 624 2 West 632 3 West 633 4 West 634 2 Center 642 3 Center 643 4 Center 644 Private 645 Convalescent 650 Maternity 655 Contagious 660 South Department 670 Research Bldg. 675	Chief Resident Phys. 700 House Physician 701 Interns 702 Ambulance 703 Central Records 721-2 Appliance Shop 730 Pharmacy 740 Social Service 750 Miscellaneous 760	Anesthetic 810 Dermatology 820 Internal Med. 831-3 Neurology 840 Ophthalmology 850 Oral Surgery 870 Otolaryngology 880 Roentgenology 900 Surgery 911-1243 Physiotherapy 914	Clinical Lab. 950 Basal Metab. 951 Blood Chem. 952 Bacter. Lab. 953 Lab. Dis. 954 Serology 955 Pathology 956 Research 957 Sensitization 958

Chart A

the efficacy of the procedure. Under these recommendations the functional and geographical analysis may be combined in the same set of symbols.

The functional analysis is outlined by first dividing the hospital into three main groups.

Group I—General Expense Divisions

- 100 Administration
- 200 Physical Plant
- 300 Stores

Group II—Divisions Relating to Care of Patient in Ward and Room

- 400 Dietetics
- 500 Housekeeping
- 600 Nursing

(Nursing Education)

Group III—Special and Clinical Care Division

- 700 General
- 800 Clinical
- 900 Laboratories

The geographical division is accomplished by a subdivision of the two right-hand digits of each division symbol:

Main Building: east wing 20; west wing 30; central wing 40.

Outlying Buildings: south department 50; maternity 60; contagious 70; children's ward 80; homes—staff and employees—90.

Floor levels are indicated by the addition of the floor level number to the above symbol.

Under this system, the nursing station on the fourth floor, east wing, main building, would be:

(600 Nursing)
(20 East)
(4 Fourth Floor) — 624.

The diet kitchen on the second floor center would be 442. The operating floor (3 Center) 643.

This system assigns to each organization unit a symbol that combines the functional and the geographical analysis of income and expense in a manner that makes possible the intelligent comparison of the vital factors of all important subdivisions. Chart A gives a typical outline, applying this idea to hospital organization.

The following outline shows the possibilities of the second section of the symbol system.

(A) Divide all expenditures into two classes

1. Operating Expense
2. Capital Outlay
(Lands, Buildings, Equipment)

(B) Divide all items in the first group as follows:

- 11—Personal Services
- 12—Commodities

(C) Divide all items in the second group as follows:

- 21—Equipment
- 22—Lands and Buildings

(D) The following are instances of further subdivisions of 11 and 12:

- 111—Salaries—Teaching—Research
 - 1111—Instructors in School of Nursing
 - 1112—Instructors in Hospital School for Crippled Children
- 112—Salaries—Officers and Superintendents.
 - 1121—Superintendent and Immediate Assistants
 - 1122—Heads of Departments and Immediate Assistants
 - 1123—Heads of Subdepartments and Supervisors

and continuing through the desired classification.

- 128—Materials and General Supplies
 - 1281—Foodstuffs
 - 12812—Milk, cream, cottage cheese
 - 12814—Meat

Note: In the above it will be observed that the underscored numbers containing three digits can represent the general classification of the parent organization in cases where the hospital forms a part of a larger institution, such as a university.

Under the foregoing system, an expense ac-

BUDGET ALLOWANCE 1928 - 1929						
	DEPARTMENT TOTALS		DIVISION TOTALS			
	PERSONAL SERVICES	COMMODITIES	PERSONAL SERVICES	COMMODITIES	TOTAL EXPENSE	% OF TOTAL
I GENERAL EXPENSE						
100 Administration Division						
101 Executive Office	\$ 3,190.00	\$ 535.40				1.44%
102 Business Office	8,569.20	1,093.80				3.74%
103 Post Office	274.00	27.90				.11%
104 Telephone Operators	480.00	6.00				.19%
175 Research Building	80.00	15.00				.04%
Total Administration			\$ 12,593.20	\$ 1,678.10	\$ 14,271.30	
200 Physical Plant - Division			1,952.00	25,127.20	27,079.20	10.47%
300 Store Room - Division			2,559.80	198.60	2,758.40	1.08%
Total General Expense Group			\$ 17,135.00	\$ 27,003.90	\$ 44,148.90	17.07%
II CARE OF PATIENTS IN WARD AND ROOM						
400 Dietetics - Division Total			18,043.00	35,556.70	53,601.70	20.72%
500 Housekeeping - Division Total			15,721.60	8,609.95	24,331.55	9.41%
600 Nursing Care						
690 Nursing Education						
Total Nursing Division			64,174.50	15,670.07	79,844.57	30.88%
Total Care of Patients in Ward and Room Group			\$ 97,939.10	\$ 59,836.72	\$ 157,775.82	61.01%
III SPECIAL AND CLINICAL CARE						
700 General Units Division						
700 Chief Resident Physician	400.00	13.90				.16%
701 House Physician's Office	270.00	22.50				.11%
702 Internes	1,110.00	945.00				.79%
703 Ambulance	302.40	45.60				.13%
721-22 Central Records	2,347.50	266.10				2.18%
730 Appliance Shop	1,358.40	1,730.60				1.19%
740 Pharmacy	875.00	3,612.10				1.73%
750 Social Service	6,774.20	590.40				2.85%
760 Miscellaneous	-	7,573.00				2.82%
Total General Units Division			\$ 16,437.50	\$ 14,697.20	\$ 31,134.70	12.03%
800 Clinical Units Division						
810 Anaesthetic	\$ 1,436.00	\$ 1,522.70				1.14%
820 Dermatology	-	62.40				.02%
831-2-3 Internal Medicine	2,505.00	314.70				1.09%
840 Neurology	150.00	81.40				.09%
850 Gynecology	100.00	44.80				.06%
860 Ophthalmology	-	639.40				.25%
870 Oral Surgery	100.00	68.40				.05%
880 Otolaryngology	-	46.40				.02%
890 Pediatrics	170.00	54.30				.09%
900 Roentgenology	4,270.50	4,006.00				3.20%
911-12-13 Surgery	3,550.00	476.60				1.57%
914 Physiotherapy	1,635.00	75.80				.66%
Total Clinical Units Division			13,918.50	7,390.90	21,309.40	8.25%
950 Laboratories Division						
950 Clinical Laboratories - General	\$ 411.66	\$ 11.70				.16%
951-52 Basal Metabolism & Blood Chemistry	520.00	5.20				.20%
953 Bacteriology Laboratory	480.00	316.60				.31%
954 Laboratory Dispensary	100.00	182.20				.11%
970 Serology	780.00	134.40				.35%
960 Pathology	965.00	278.90				.48%
975 Research	80.00	.60				.02%
980 Sensitization	-	27.00				.01%
Total Laboratories Division			3,316.66	956.60	4,273.26	1.64%
Total Special & Clinical Care Group			\$ 33,672.66	\$ 23,044.70	\$ 56,717.36	
Grand Total Expense			\$148,746.76	\$109,887.32	\$258,634.08	100%
			57%	42%	100%	

Chart B

count symbol would result from the hyphenated combination of the two main groups of symbols. For instance, an item of meat requisitioned for the diet kitchen on the third floor, east of the main building, would be charged to account number 423-12814. Ward helpers assigned to duty on the fourth floor center would carry the symbol

644-1167. An expense distribution based upon such a symbol system will dovetail perfectly with any adequate pay roll and stores system, and will provide a daily control of operating expenses.

Stores and pay roll systems for hospitals need not be complicated procedures. The pay roll system should be designed first with a thought to the

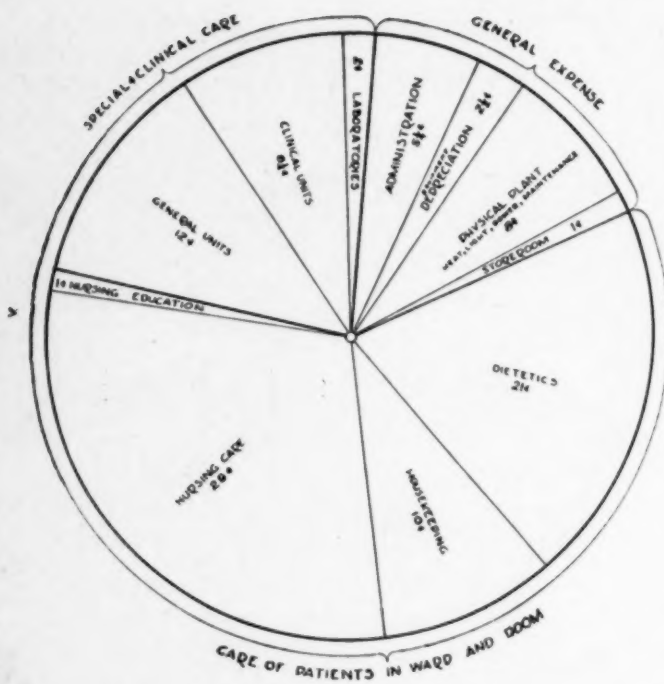


Chart C

safety factor. Proper checks and balances should insure honesty throughout, and at no point should an officer or employee be burdened with an opportunity for irregularity. The institution owes to its staff and employees an obligation to keep them free from such opportunities, and no method of

business procedure should be tolerated that offers any specific individual the chance for dishonesty or for the exercise of any wide discretion that might involve questionable practice.

After due attention has been paid to this phase of the pay roll system, consideration should be given to the method of reporting time and the distribution of pay roll expense. It is important that adequate controls be established to insure the proper spreading of the entire pay roll over the expense ledger. Every officer and employee should be assigned to a definite classification, which could be varied only upon due authority. It is extremely important that pay roll classification be a definite matter and not subject to the changing whim of pay roll clerks. If the personnel is large enough to employ machine bookkeeping, accompanied by some mechanical method of reproducing names and rates, it is well to include with these items the classification symbol, and thus eliminate individual judgment and insure regular treatment from period to period.

A stores system is subject to the same suggestions as the pay roll system. The first requirement is that of adequate protection to the institution and to the employees. It is important to provide a pricing system that will insure total cost distribution. The same necessity exists for some

WARD & ROOM PRICES	\$1.00	\$1.50	\$2.00	\$2.50	\$3.00	\$3.50	\$5.00	\$6.00	\$10.00	TOTAL BEDS	ESTIMATED PERCENTAGE OF CAPACITY	ESTIMATED DAILY INCOME	ESTIMATED YEARLY INCOME
MAIN BUILDING													
622 2 East			8		5					13	95	\$ 29.45	
632 2 West			3	3	3					9	93	20.93	
642 2 Center							3			3	92	13.60	
623 3 East			8	3	5					16	95	36.59	
633 3 West			8	3	5					16	94	36.19	
643 3 Center							3			3	95	14.10	
624 4 East			8	3	5					16	96	36.96	
634 4 West			8	3	5					16	96	36.96	
639 4 Center							6			6	100	30.00	
644 4 Private							10		2	12	71	49.70	
TOTAL MAIN BUILDING												\$ 304.68	\$ 111,208.20
SOUTH DEPARTMENT													
CONTAGIOUS	3		12							15	34	9.16	3,350.70
MATERNITY	9		5							14	72	14.25	5,101.25
CONVALESCENT			10							10	70	14.00	5,110.00
TOTAL BEDS	12		85	25	28		22		2	174			
TOTAL ESTIMATED WARD AND ROOM INCOME													\$ 142,937.65
TOTAL ESTIMATED MISCELLANEOUS INCOME AS PER EXHIBIT "B"													117,075.44
TOTAL ESTIMATED INCOME													\$ 260,013.09

Chart D

method that will produce uniform classification of stores issues. Again we find it a little easier to accomplish this in connection with large units, which avail themselves of modern stores accounting devices.

It is obviously important that careful attention be paid to the pay roll and stores systems in connection with labor and material distribution. They hold the key to successful control of expenditures, in that they provide the raw material, so to speak, upon which the entire system rests. It is not within the scope of this article to discuss the various methods that can profitably be employed by hospitals to accomplish their pay roll and stores accounting. Suffice it to call attention thus briefly to some of the major requirements.

It is about as profitable to discuss whether the egg precedes the hen or the hen the egg, as to try to determine rationally the relation of the budget and the expense distribution system. Each is indispensable to the other and neither can be created entirely without the aid of the other. The first attempts at either are apt to be of an extremely experimental nature, and it is only after the expense distribution has been followed steadily for several periods along the lines of the program, and both have been adjusted constantly to reveal the proper facts, that they become of sufficient value to constitute control agents in the management of the business of the institution.

Needless to say, the program of procedure should adhere strictly to the expense ledger system, both as to pay rolls and commodities, and should be so constructed as to be capable of constant comparison from month to month.

Carefully Estimate Income

In addition to merely outlining the expense program, there should be a careful planning of anticipated revenue. Charts B, C, D, E and F represent outlines of a hospital budget based upon the expense accounting system herein discussed. These tabulations would ordinarily precede the detail of the budget. Tabulation B is a summary of the budget, showing distribution by organization unit, both in amount and in percentage form. The graphical analysis, C, portrays this information visually, giving the management a correct orientation regarding this important factor.

Then follows a tabulation of anticipated income, D. A study of this will reveal that previous occupancy experience is tabulated in column 11, which gives a more accurate picture than a composite shrinkage of 85 per cent. Table E shows a reasonable method of anticipating miscellaneous income.

The most interesting and perhaps the most

ESTIMATED MISCELLANEOUS INCOME		
1928 - 1929		
	Actual Income for six months ending June 30, 1927.	Estimated Income 1928 - 1929 (Twice amount of actual for six months ending June 30, 1927)
Nursing	\$ 12,369.71	\$ 24,779.43
X-Rays	6,086.41	12,172.83
Anaest. & Operating Room	6,073.46	12,146.92
Professional Fees	3,193.30	6,386.61
Appliances	5,092.98	10,185.96
Costs	1,192.63	2,385.26
Optical Goods	492.03	984.06
Physiotherapy	2,652.25	5,304.50
Treatments	746.07	1,492.15
Tests	2,099.67	4,199.34
Electro-Cardiogram	353.90	707.80
Cafeteria	3,756.30	7,512.60
Dressings	2,311.29	4,622.58
Diet	1,266.58	2,533.16
Meals	138.29	276.58
Pharmacy	1,460.28	2,920.56
Registration	2,313.18	4,626.37
Transportation	311.18	622.37
Transfusions	611.30	1,222.60
Ambulance	140.50	281.00
Laundry	62.62	125.25
Medical & Surgical Supplies	101.92	203.84
Miscellaneous	162.84	325.68
Extractions	195.97	391.94
Fillings	42.67	85.35
Thermometers	10.09	20.19
Stimson Memorial Prof. Fees	17.50	35.00
Stimson Memorial Lab. Fees	60.75	121.50
Health Service Supplies	165.70	331.41
Board for Psycho. Nurses	74.62	149.25
Salaries for Psycho. Nurses	40.94	81.88
Uniforms	104.50	209.00
Occupational Therapy	50.61	101.22
Occupational Therapy Basketry	6.63	13.26
Occupational Therapy Sewing	2.46	4.92
Layette	19.63	39.27
Special Dinners	49.61	99.23
Refers-Out Patient Department	31.00	62.00
Subsequent Visit Cards	243.54	487.08
	\$57,537.69	\$115,075.44
*General Laboratory Fee		2,000.00
Total Estimated Miscellaneous Income		\$117,075.44
* New Revenue Item Imposed, March 1, 1928		

Chart E

profitable part of the entire budget is tabulation F. Here we have an attempt to correlate anticipated income and expense by operating divisions. First the divisional totals are listed and the general expense items spread upon groups two and three. In this instance this spread of overhead is accomplished on the "dollar basis," which might not be most desirable in all cases. It is the simplest method, but in certain cases it would be inaccurate.

The second section of this report shows a correlation between anticipated expense and revenue, and the establishment of normal deficits and surpluses. This is the result of indirect services performed by one division for another. For instance, the housing and feeding of nurses are charged to the division of dietetics and housekeeping. In the absence of a practical plan for re-allocating this charge, it is desirable to know in advance how these divisions stand, and to set up a normal expectancy in each instance. Thus, if the estimate should prove accurate, the divisions will show deficits and surpluses as scheduled. If variations occur, it is a signal for investigation and adjustment. The plan has proved successful in at least one instance, where actual expenditures varied less than one half of 1 per cent on distribution, and the deficits and surpluses came within 2 or 3 per cent of the forecast for the fiscal period. Such a condition shows clearly the fact that expenditures and revenues are meeting the estab-

lished requirements and offers a valuable medium by which to follow closely these vital factors.

It is exceedingly important for the superintendent of the hospital to realize that no matter how small the institution may be, it is possible for him to have a thorough business procedure that will make possible such control as is here outlined, without enormous prohibitive expense. If an accounting system is planned by an expert with care and foresight, it should grow with the institution without fundamental alteration. As the institution reaches certain stages, in an ex-

pansion program it is, of course, possible to take advantage of many labor-saving devices, which reduce the drudgery that would otherwise accompany an increased volume of work.

A study of one particular institution produces some interesting results in regard to this particular question. It was spending \$40,000 a year for its business office. The task of keeping pace with the rapid expansion of the institution was so great that it was impossible to take care even of the routine daily work. Analysis of any kind was absolutely prohibitive but the budget for the de-

GENERAL SUMMARY OF ESTIMATED INCOME AND EXPENDITURES									
ANALYSIS OF ESTIMATED EXPENDITURES									
DIVISION									
NO. NAME	SALARIES (1)	COMMODITIES (2)	TOTAL EXPENSE (3)	% OF TOTAL (4)	NON-EARNING DEPARTMENTS GENERAL EXPENSE (5)	EARNING DEPARTMENTS (6)	EARNING DEPART- MENTS % (7)	APPORTION- MENT OF NON- EARNING EXPENSE (8)	TOTAL EXPENSE (9)
GENERAL EXPENSE									
100 Administration	\$ 12,593.20	\$ 1,676.10	\$ 14,271.30	5.5%	\$ 14,271.30				
200 Physical Plant & Maintenance	1,952.00	25,127.25	27,079.25	10.5%	27,079.25				
300 Stores	2,569.60	196.60	2,766.40	1.1%	2,766.40				
CARE OF PATIENTS IN WARD & ROOM									
400 Dietetics	18,043.00	35,558.70	53,601.70	20.7%		\$ 53,601.70	25.1%	\$ 11,076.87	\$ 64,680.57
500 Housekeeping	15,721.60	8,609.95	24,331.55	9.4%		24,331.55	11.3%	4,967.70	29,319.25
600 Nursing	64,474.50	15,670.06	79,844.56	30.9%		79,844.56	37.2%	16,419.68	96,264.27
SPECIAL & CLINICAL CARE									
700 General Units	16,437.50	14,697.20	31,134.70	12.0%		31,134.70	14.5%	6,400.14	37,534.84
800-911 Clinical Units	13,918.50	7,390.90	21,309.40	8.2%		21,309.40	9.9%	4,369.75	25,679.15
950 Laboratories	3,316.66	956.60	4,273.26	1.7%		4,273.26	2.0%	882.78	5,156.04
Grand Totals	\$148,746.76	\$109,887.38	\$258,634.14	100%	\$44,136.95	\$214,495.19	100%	\$44,136.92	\$258,634.12
(1) For detail see schedule D (2) Represents total Expense for each Department. (3) This percentage indicates the estimated distribution of each dollar expended. (4) & (5) For the purpose of analysis divisions of Administration, Physical Plant and Stores are considered as a burden or overhead. (6) Indicates the ratio of estimated expenditures over the "Earning" division. (7) Shows the distribution of estimated expenditures on "Non-Earning" divisions on the basis of ratio *7. (8) Shows the entire estimated expenditures distributed over the "Earning" divisions.									
COMPARISON OF ESTIMATED EARNINGS AND EXPENDITURES									
JANUARY 1, 1928 - DECEMBER 31, 1929									
EARNING UNITS									
	CARE OF PATIENTS IN WARD & ROOM			SPECIAL & CLINICAL CARE			TOTALS		
	400 DIETITICS	500 HOUSEKEEPING	600 NURSING	700 PROFESSIONAL CARE GENERAL	800 CLINICS	900 LABORATORIES			
TOTAL EARNING UNIT EXPENSE									
(1) Including overhead (column 9 above)	\$ 64,680.57	\$ 29,319.25	\$ 96,264.27	\$ 37,534.84	\$ 25,679.15	\$ 5,156.04	\$ 258,634.12		
(2) Distribution Ratio	.339	.154	.507				100%		
(3) Distribution of estimated Ward and Room earnings	48,455.98	22,012.45	72,469.57				142,938.01		
(4) Distribution of estimated Miscellaneous Earnings	10,931.84		38,104.63	15,657.20	41,434.71	10,947.21	117,075.71		
TOTAL ESTIMATED INCOME									
(5) Line 3 & 4	59,387.82	22,012.45	110,574.20	15,657.20	41,434.71	10,947.21	260,013.62		
(6) Estimated Operating Surplus Line 5 minus line 1			14,309.93		15,755.56	5,791.17	1,379.48		
(7) Estimated Operating Deficit Line 1 minus line 5	5,292.75	7,306.80		21,877.64					

Chart F

partment was not enlarged. Bad conditions finally forced a change of administration, and with it a change of policy. This change increased the expense of the business office to \$85,000, but the new organization was able to cope with the situation, and at the same time had an opportunity to analyze the operations of the institution.

As a result, savings on collections of accounts alone, more than offset the increase in the pay roll. In addition, the added information, given to the management of the institution, made extensive savings possible, not only in improved economical methods of operation, but also by determining the true cost of service rendered. This revealed the necessity of increasing rates on certain items, in order to cover the cost of the service, thus preventing direct cash losses.

Business Methods Needed

This example brings out the important fact that halfway business methods are much more expensive in the long run than thoroughgoing methods, such as are employed in commercial fields. The public is being slowly educated to demand sound business methods, and to respect the institution that recognizes the fundamental requirements of good business. The public is also beginning to inquire whether or not it is possible to put its charities on a businesslike basis. Community chest movements give evidence of this tendency. Social legislation, providing for hospitalization on a direct cost basis, indicates another effort in this direction. Promiscuous scattering of charity is looked upon with growing disfavor, and to meet this situation the hospital superintendent must constantly emphasize the fact that his institution is operated in a businesslike manner, and is in position to demand charity only in terms of units of service rendered.

Some attempts are being made to require the hospital to submit to the community chest committee actual statements of service rendered to specific patients worthy of charity, before payment out of the community chest is made. In this way the hospital actually earns its share of the community chest drive, and does not merely receive a lump sum to offset a blanket deficit, which may or may not be due to charitable services. This attitude puts upon the hospital the obligation of balancing its budget, and insisting upon being paid for every unit of service rendered, either by the patient or from some fund.

If the units of service are priced at cost plus a reasonable margin of safety, there is no reason for the existence of a blind deficit. It is reasonable to expect that when the public realizes that its money is being spent in such a businesslike

manner, it will be more liberal in contributing. Sound accounting methods, supported by careful analysis of operating income and expenditures, will do a great deal to establish a greater respect for the noble work that is being done by the hospitals of the country.

Don't Invite Trouble, Avoid It

One of the most troublesome problems of a hospital is that of collecting delinquent accounts. Therefore, when a patient, accompanied possibly by a friend or relative, arrives at the receiving room of a hospital and fills out the proper admission records, the receiving clerk should first of all ascertain who is to be responsible for the payment of the bills. He should then carefully explain that the bill for the first week is payable in advance. The patient should also be informed that the extras, such as operating room, laboratory, x-ray and anesthetic fees will appear on the bill for the second week, and that settlement of the account in full must be made before he leaves the hospital.

Even if all this information is contained in printed literature, it is advisable, in order to assure a clear understanding, that the patient be informed upon entering the hospital as to the rules and requirements regarding the payment of hospital accounts.

If the patient is unable to meet these requirements, he should be immediately referred to the business manager. If it is then found that he cannot pay cash and needs time for payments, he should be sent to the person in charge of arranging for collections, so that a clear and definite agreement as to terms, concessions and payments may be made. The business manager, in handling these cases, should be considerate, thoughtful, diplomatic and sympathetic.

In making concessions to the patients, a careful investigation concerning his financial circumstances should first be made. In some cases, when it is possible although inconvenient for prompt payment to be made, it is good policy for the hospital to make a reduction in the bill as an inducement for immediate action in clearing up the account.

Such are the opinions of Dr. F. O. Barz, business manager, Bethesda Hospital, Cincinnati.

St. Thomas's House Opened to Medical Students

The St. Thomas's House, London, has recently been completed and rooms are now available to students in medicine and members of the professional staff of St. Thomas's Hospital, at a reasonable rent. This is the regular home of the Medical School Club.

The building is six stories in height. In the basement are cloak rooms, lavatories, kitchen stores and staff mess rooms, besides a large room for electrical equipment. The ground floor has offices, dining room, kitchen, and steward's dispensary. The first floor has a card room, club and reading room, with a stage for entertainment, and billiard room. The upper four floors are the bed rooms and living quarters, with accommodations for seventy-two beds.

The cost of construction was over \$280,000.



Halifax District Hospital

This Florida hospital is of Spanish design and is of stucco and buff terra cotta, with a mission tile roof, in shades of warm browns and buffs. An ornamental tower is on the roof, over the main entrance.

Combining Beauty with Practicability in a Southern Hospital

By CHARLES C. WILSON

Architect, Columbia, S. C.

RAPID strides are being made by the communities of the South toward better hospitalization. In nearly every one of the southern states building projects are underway or new hospitals have recently announced their openings. Institutions that have been in existence for many years are building additions so that they may accommodate the needs of the community by offering more adequate service.

On account of the phenomenal growth of Florida and the rapidity with which it developed, it was but natural that the hospital problem should be an acute one, and it is to the credit of the state that it was met and solved by the people nearly as fast as it arose. New buildings were devised for the care of the sick and, as has been the case with all Florida projects, the best and most progressive steps were taken. Other parts of the country were studied, and the best features of the acknowledged leaders were appropriated and adapted to local conditions in the planning of the Florida hospitals.

Climatic conditions, the character of the population, probable future growth and other factors entered into the planning, particularly in the established cities in the state, and the result has been that

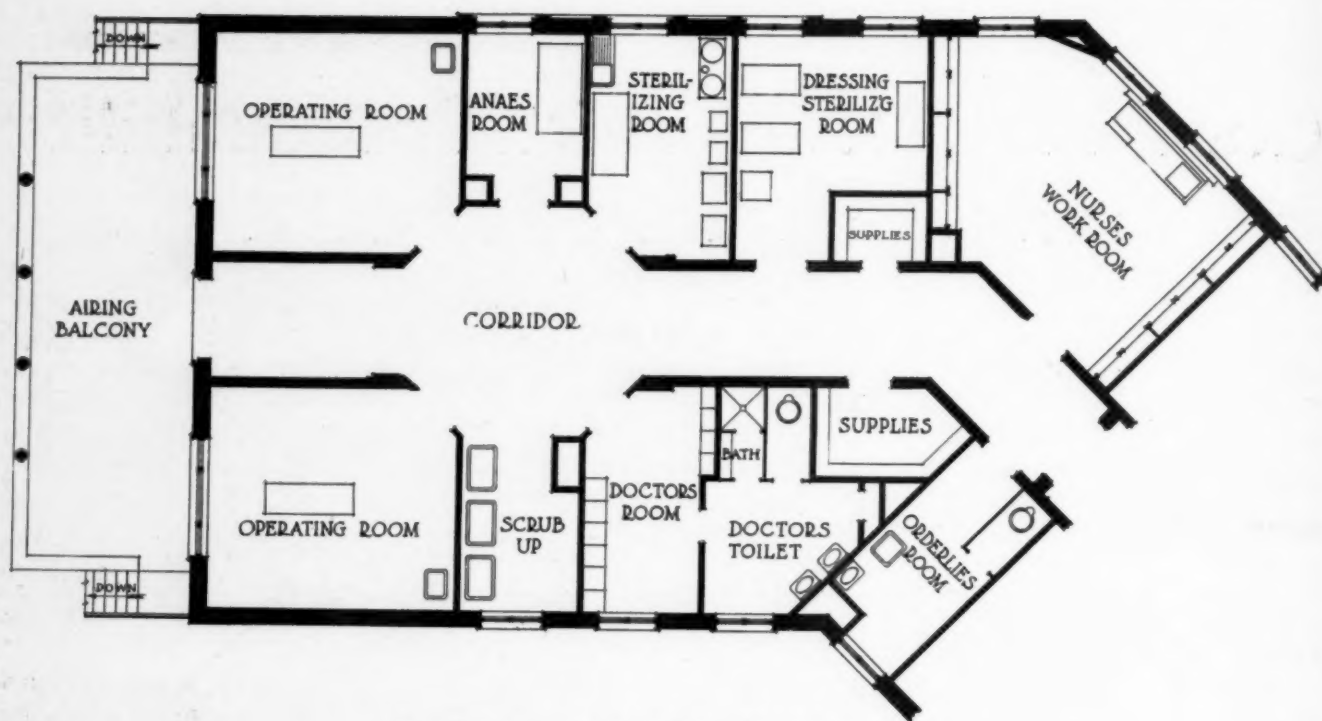
Florida today has several of the most modern and practical hospitals in the United States.

Beauty, however, was at no time sacrificed, and a striking example of the combination of beauty and practicability is to be found in the recently completed Halifax District Hospital at Daytona Beach. Daytona is and has been for many years one of the progressive cities of the south, not dependent upon the rise or fall of the real estate

market, but established upon a firm foundation of industry. It was but natural, of course, that this city should share in the prosperity of Florida, and it had the additional advantage of not being materially affected by the slump in the realty market. In other words it was not by any means a "boom" town.

When the hospital was first considered the site was selected with care, plans for the future were outlined in detail and the materials that would best withstand the climate, and would at the same time be attractive, were chosen. Architects' plans were drawn and were gone over minutely by the building committee and the superintendent. The newest types of equipment were considered and discussed, building materials and built-in equipment were matters of close study, with the result that the hos-





Surgical department, Halifax District Hospital.

pital today is considered one of the show places of Florida and is unusual in many ways.

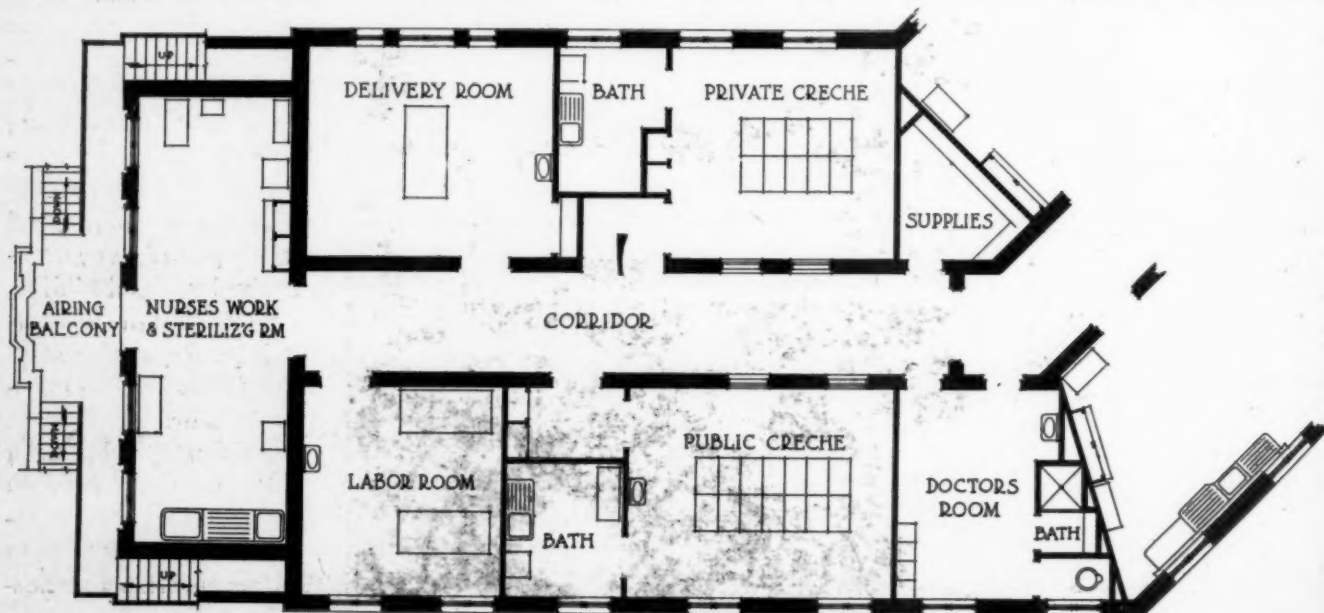
This hospital is one of the notable buildings of 1927. It is intended to serve a district in Volusia County lying along Halifax River, from Ormond on the north to New Smyrna on the south, centering at Daytona Beach. It was financed by a public bond issue of \$750,000 and is in charge of a commission, consisting of F. J. Niver, chairman, Don P. Shockney, secretary, Henry W. Haynes, George N. Rigby and Col. Walter R. Weiser.

The building was designed by Wilson, Berryman & Kennedy, architects, Columbia, S. C., and upon dissolution of that firm was carried to com-

pletion by the senior partner, Charles C. Wilson. Stevens & Lee, Boston, served as consulting architects.

The hospital is located in Daytona Highlands on the crest of a sandy ridge fifty feet above the sea, insuring perfect drainage. It is surrounded by a beautiful grove of pines and the grounds are being planted in formal gardens, with shrubbery and a wealth of flowers, as is possible only in Florida.

The building is three stories in height, of Spanish design, in stucco and buff terra cotta, with a mission tile roof in blended shades of warm browns and buffs. The two elevator penthouses are treated as ornamental towers, and there is



Maternity department, Halifax District Hospital.

another for ventilation on the center of the roof.

The construction has masonry walls, with wall bearing reinforced concrete slabs for floors and ceiling. The roof is a gypsum slab on steel trusses, and the nonbearing partitions are of gypsum block. The building is fireproof throughout.

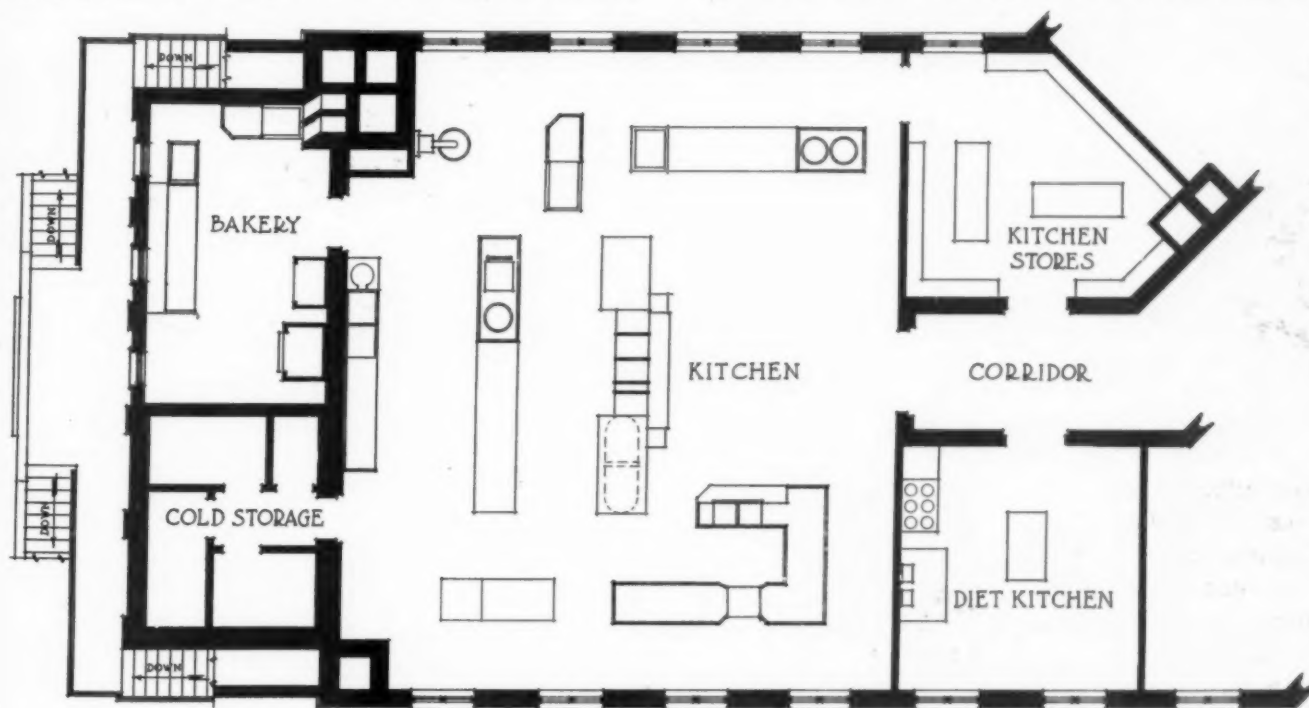
The interior finish is of marble, tile and hard plaster, painted in special hospital tones, varying to suit different types of patients. The doors are mahoganized birch, inlaid with white holly. The floors are of terrazzo and tile.

The capacity of the hospital is 125 beds, and it has the following departments for general hospital work: administration; reception and admittance; social service; laboratory; mortuary and autopsy; out-patient; accident; x-ray and fluoro-

There are seven independent electric systems: illumination, x-ray and fluoroscopic, power, cooking, silent signals from each bed, telephones at each bed, radio for each bed.

Heated by Vacuum System

The building is heated by a vacuum system with direct radiation from two smokeless boilers. There is also one high pressure boiler, supplying steam for heating water, cooking, laundry and sterilizers. The water is heated in a solid copper tank with a steam coil. All boilers are operated on oil fuel. The steam pipe, both high pressure and low pressure, of genuine wrought iron, is carried from the boiler room direct to the attic, loops around the building, feeds down to the radi-



Kitchen department, Halifax District Hospital.

scopic; surgical; maternity; children; isolation, and a well equipped sanitarium.

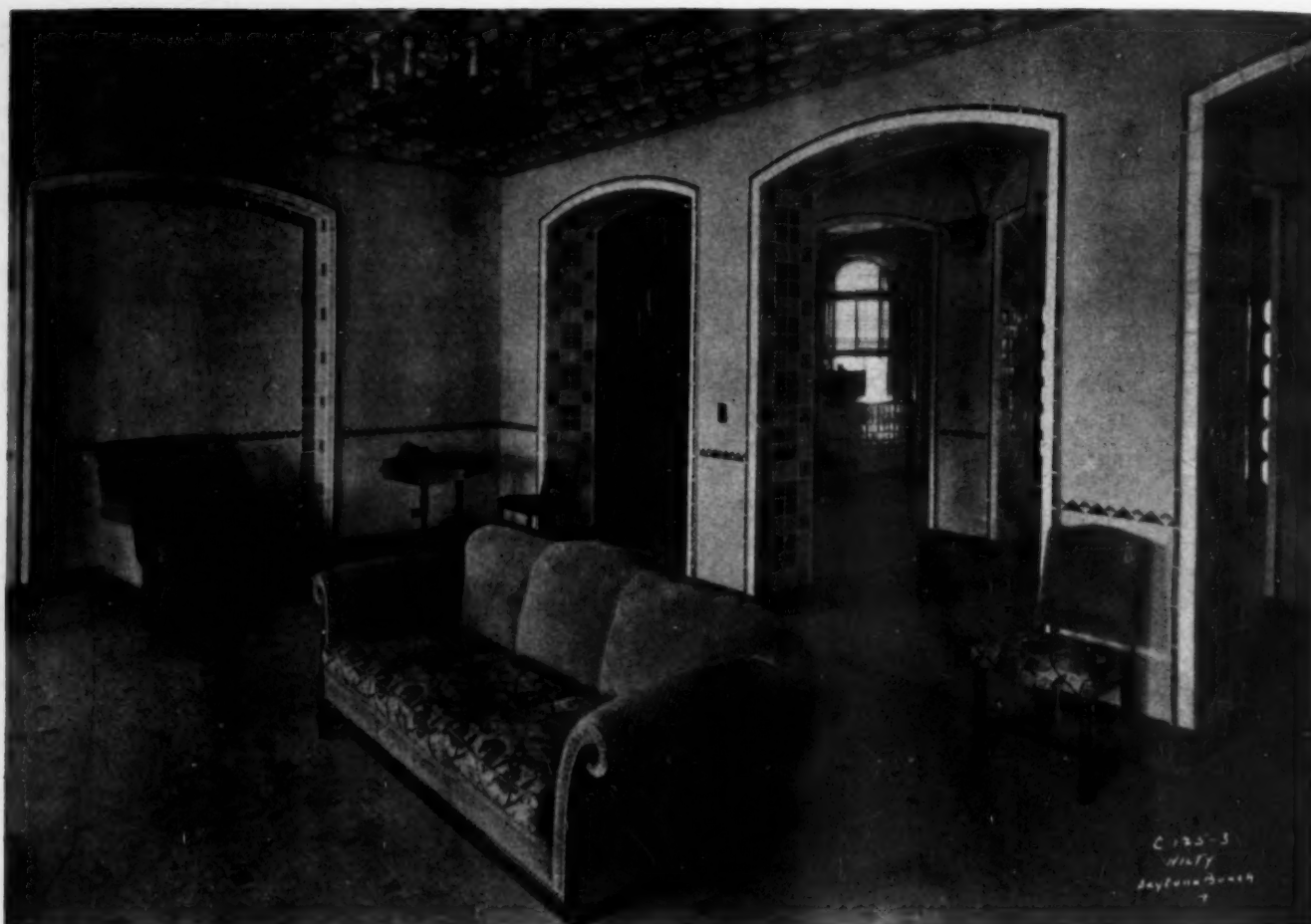
There are spacious loggias and terraces in three tiers at the end of each of the four wings, which, with their outside Spanish stairs, serve not only as airing balconies but as convenient exits to the ground, and add greatly to the architectural interest of the building.

There is, of course, a full complement of utilities, such as sink rooms, kitchens, dining rooms, serveries, refrigeration, laundry, with linen chute, incinerator, with chute, workrooms, storage rooms, and a general repair shop. There are three electric elevators, two for passengers and one for service, and two main stairways from the ground floor to the attic, one service stair to the second story and four sets of outside stairs.

ators and sterilizers, connects on return loops under the first floor and is carried back to the receiver and pumps in the boiler room.

Since the windows may be kept open practically all the time in this climate, no other ventilation was deemed necessary, except for bathrooms, toilets, laboratory, mortuary, boiler room, laundry and kitchen. The three latter are connected through ducts and exhaust fans to large vertical flues extending above the roof. Ventilation of the other spaces is provided by vertical shafts to the attic, where they are connected by lateral branches to large ducts leading to an exhaust fan chamber in the ventilating tower in the center of the building.

* Fire protection is provided by a six-inch extra heavy water main, running transversely through



A comfortable davenport and easy chairs are provided in the waiting room, which has a richly decorated ceiling.

the building with post indicator valves fifty feet from the building on each side, and engine connections on the outside walls. There are two four inch branches from this main, running to points near the ends of the building and rising to the attic, with cabinets on each floor with standard equipment.

The hospital has an exceptionally complete equipment of sanitary plumbing with sink rooms, toilets, bathtubs, showers and lavatories in every part of the building, and each technical department is provided with its appropriate special fixtures. Each room and ward is provided with a lavatory and has direct access to a bath and toilet, while many of the rooms, including all in the sanitarium wing, have private baths.

The fixtures have white metal fittings, and generally have wrist or elbow action. The soil pipe is extra heavy cast iron, the supply pipe is of wrought iron galvanized, and is concealed.

Ample Refrigeration Is Provided

There are four built-in cold storage boxes adjacent to the main kitchen, a garbage freezer beneath the kitchen, and an ice storage room adjacent to the service entrance and a six-body cooler in the mortuary, each refrigerated by electric

unit cooling coils. There are eight complete electric unit cabinets in the serveries, in the diet kitchens, and in various parts of the building, and eleven water cooling units with bubblers and spouts for ice water service.

There is complete steam sterilizing equipment in the surgical, maternity, accident and other departments for dressings, instruments, utensils and water.

Kitchens Are Well Equipped

The kitchens and serveries are fully equipped with oil and electric ranges, broilers, bakery, kettles, toasters, coffee and tea urns, steam tables, hot food conveyors and dishwashers, and the laundry has tubs, washers, tumbler, extractor, flat work ironer, ironing boards and body presses.

The cost of the building was \$524,925, or \$4,191 per bed and sixty-three cents per cubic foot. The cost of special fixed equipment, including laundry, kitchen, serveries, refrigeration and sterilizers, was \$47,992 or \$384 per bed.

All mechanical equipment is in charge of a capable engineer of wide hospital experience, who takes pride in it and keeps everything in the best condition. His boiler room is as clean and polished as the reception room.

Butterworth Hospital Considers the Patient's Pocketbook

By ROBERT W. IRWIN

President, Board of Trustees, Butterworth Hospital, Grand Rapids, Mich.

IT HAS been the purpose of the trustees of Butterworth Hospital, Grand Rapids, Mich., to plan the work of that institution so that it may be of maximum benefit to the community. It is not just a doctors' workshop. It does afford an excellent place, equipped with all modern appliances, in which a doctor can do his work, but beyond this it has a broader responsibility. It should stand in the forefront in every progressive movement for the bettering of health conditions in the city. It should take a broad position upon all advanced thought for hospital service that emanates from responsible sources. It should plan its policies entirely upon the grounds of the greatest good to the people of Grand Rapids.

The superintendent recently placed before the board of trustees a number of suggestions along these lines, and these met with immediate approval.

Laboratory and x-ray work are assuming greater importance in diagnosis. The trustees are now considering a revision downward of the rates for these services, so that they may be placed within the means of more people. While lower rates may temporarily reduce the revenue, it is expected that the increased use of the departments that will follow the reduction of rates, will soon restore the receipts to the present amount.

Why People Stay Away from Hospitals

There are times when physicians, in order to make a diagnosis, desire their patients to go to a hospital for a short time for such observation and examination as can be worked out only within a hospital, where laboratory, x-ray and other facilities are available. The cost of such a stay is unknown, because of the amount of laboratory, x-ray and other work that the physician in charge may think necessary, and this undoubtedly causes many people to refrain from going to the hospital for this service.

The board of trustees of Butterworth Hospital feels that if this uncertainty could be removed by naming a flat rate for a two days' stay, which will cover all departmental charges, including x-ray, laboratory and other examinations, it would

enlarge the hospital's field of usefulness in the matter of diagnosis. To this end a flat rate has been established for a two days' stay, including all services for the diagnostic work asked for by the attending physician. The rate is \$25 if the patient is in a ward or semiprivate room, and \$35 if he occupies a private room.

Hospitalize Maternity Cases

The advisability of hospitalizing maternity cases is no longer a debatable question. The benefit to be derived from such a step is well established. Last year there were 3,611 births in the city of Grand Rapids. Of these, 1,737 occurred in hospitals. Every inducement should be given to increase the percentage of hospitalized cases. Butterworth has a splendidly equipped maternity section which is not being used to capacity. Rates at the present time are a specified sum per day, with extras for the use of birth room, anesthesia and many other items, all of which make the final cost uncertain. It was felt that if a flat rate could be established, including all extras, thus removing all uncertainty regarding the cost of going to a hospital, many expectant mothers would be induced to avail themselves of the advantages that a hospital affords. With this end in view, the trustees have established flat rates for maternity work that are considerably lower than the average cost under the old plan.

The average stay of maternity cases in our hospital has been ten days. The new flat rates for a ten days' stay are as follows: ward, \$40; semiprivate room, \$50; private room, \$100. In the case of ward patients a credit of \$2 per day will be allowed for any time less than ten days, with a minimum charge of \$30 for five days or less. It must be understood that the minimum flat rate does not in any way indicate the length of time these cases should remain in the hospital. This is a matter that falls entirely under the medical administration of the hospital or of the physician in charge. The statement regarding a minimum time of five days in connection with the flat rate is intended only to indicate that there will be no credit for a lesser stay than five days.

I believe that this step is a move in the direction of increasing our hospital's usefulness.

It is a strange coincidence that right at the time the trustees have been seeking an enlarged field of usefulness, there should come from the American College of Surgeons a suggestion that hospitals should join in a movement to promote periodic health examinations. The plan proposes that the hospital set aside an examining room to which any physician who is allowed to practice in the hospital may bring a patient for examination. The hospital is to supply to the practitioner every facility in the way of aids, consultants, when necessary, and laboratory tests, such as will insure a comprehensive audit of his patient's condition, the charge for the hospital's services to be a minimum of actual cost, not including any charge for the examination room.

It is proposed that when the details of the plan have been worked out, the hospital shall get behind a publicity movement to induce people to have periodic health examinations.

To my mind it is one of the most forward-looking steps to produce better health conditions that has ever been proposed.

To Extend Diagnostic Services

This plan is now being considered by the board of trustees of Butterworth Hospital, and I am confident that that institution will be glad to cooperate in this movement to the greatest extent possible. I am sure that our staff will give earnest consideration to the plan that comes from such an eminent source, and I believe that it will have the hearty cooperation of the doctors connected with Butterworth Hospital. I trust that it may lead to the formation within our staff of a clinical group, and that the doctors and the hospital, working together, may greatly extend diagnostic services.

This is a day of specialization in medicine and it is said that no practitioner, unaided, can make a thorough health examination. A proper examination cannot be made without the aid of laboratory technicians, nurses, interns and specialists in other lines.

I know of no profession with ideals higher than those of the medical profession. No profession is more faithful to its ideals. The aim of the profession is to protect and safeguard the patient above all, and I am sure that the board of trustees of our hospital will have in the future, as it has had in the past, the heartiest cooperation from the staff in all practical plans for increasing the institution's usefulness.

Butterworth Hospital offers to us all a wonderful medium through which we can discharge some

of our obligations to society. Let us always bear in mind that in the work we are doing in connection with this institution it is not the glory of Butterworth Hospital that we are seeking, but rather that the institution may be a medium through which we can discharge some of the duties that we as citizens of Grand Rapids owe to the community.

Census of Physical Therapy Departments Taken

In determining a hospital's rating in terms of equipment, organization and so on, it has in the past been the custom to inquire if the institution is provided with roentgen-ray departments and laboratories, according to the *Journal of the American Medical Association*, but the actual possession of or access to such diagnostic and therapeutic facilities has become so general that the question has been dropped. Instead the hospital managers are asked, "Do you have a physical therapy department?"

No specific qualifications have been established as to exactly what constitutes a physical therapy department, so, while no definite idea may be had concerning progress along this line, it is certain that nearly one-third of the hospitals questioned have set aside certain space and equipment for this work. These hospitals have a total of 354,019 patients.

Investigation has revealed that the geographic distribution of the hospitals equipped with physical therapy departments is quite even, and that they seem to be most numerous in industrial states.

Among the sixty-two orthopedic institutions in the United States, forty-two report that they have physical therapy departments. Eighty of the 168 industrial hospitals, 233 of the 563 mental and nervous hospitals, 130 of the 508 tuberculosis hospitals and 1,506 of the 4,322 general hospitals, report that they have established physical therapy departments.

Hospital Trustees' Association Suggested

The organization of a hospital trustees' association for communities where there are a number of hospitals, has been suggested by Ingersoll Bowditch, trustee, Faulkner Hospital, Jamaica Plain, Mass., as a means of arousing the interest of trustees in their hospitals. His own interest, he says, lies in the welfare and contentment of the patients who come to the Faulkner Hospital, and he is sure that if a body of trustees can be brought together, there will be some little factor in hospital management that will hold the interest of each of them.

Hospital management is connected either directly or indirectly with so many branches of the commercial and business world, that each trustee of a hospital, no matter what his business is, should be able to step in and attach himself to the study of one particular line of improvement.

If a hospital is planning a building program, it is up to the trustees to advertise the fact. In this way civic pride may be stirred up, and when the time comes to raise funds for the enterprise, the civic urge to be one of the benefactors will help the campaign along.



This Hospital in the Foothills Has a Homelike Atmosphere

By ALTA SMITH

Hot Springs National Park, Ark.

IN THE heart of Hot Springs National Park, Ark., nestled in the picturesque foothills of the Ozarks, the Sisters of Mercy have erected a million-dollar annex to St. Joseph's Hospital on a beautiful four-acre landscaped tract.

The plans for the edifice were drawn by H. F. Hess, St. Louis, and Herman-McCain, Little Rock, Ark., was the general contracting firm. The building is five stories in height and of Gothic design. It is fireproof and soundproof.

The construction is of concrete and steel, in the shape of a "T," with the main wing having a frontage of 221 feet, and a depth of 51 feet. The central wing, forming the stem of the "T," extends back 103 feet from the main wing and has a width of 65 feet. There is a row of ornamental towers extending above the roof of the main wing. The exterior of the building is of gray mat-faced brick, trimmed with Bedford stone.

The hospital has a capacity of 158 beds, 118 of these being in private rooms, each with a spacious trunk and clothes closet, lavatory and toilet. Forty of these rooms have private baths, in addition to the other conveniences. Forty of the beds are in wards where charity patients are cared for. All of the wards are on the fourth floor of the center wing. The bath house, where the Hot Springs thermal baths are administered, is on the

second floor of the same wing. On the top floor there are three completely equipped operating rooms, each arranged so as to receive light from all directions. Adjoining the operating rooms is a laboratory equipped to fill every requirement of a hospital.

The hospital is served by two elevators and three stairways, all conveniently located.

Each of the private *de luxe* rooms is attractively furnished with a large dresser, a bed of hotel height, a double-deck spring, a writing desk and chair, a night stand, a grip stand and a large and comfortable tapestry upholstered chair. The terrazzo floor is covered with a rug of pleasing oriental design.

In other words, the whole idea behind the furnishing of the first three floors is to make the rooms cheery, and not suggestive of a hospital atmosphere. Special color combinations were planned especially for the hospital.

On the fourth and fifth floors the rooms are as cheerful as those below, but the beds are of standard hospital height for the convenience of the nurses, as these rooms will be used by patients who will be confined to bed for some time.

A large solarium, equipped with fiber wicker furniture, beautifully upholstered, is another pleasing feature of each floor.

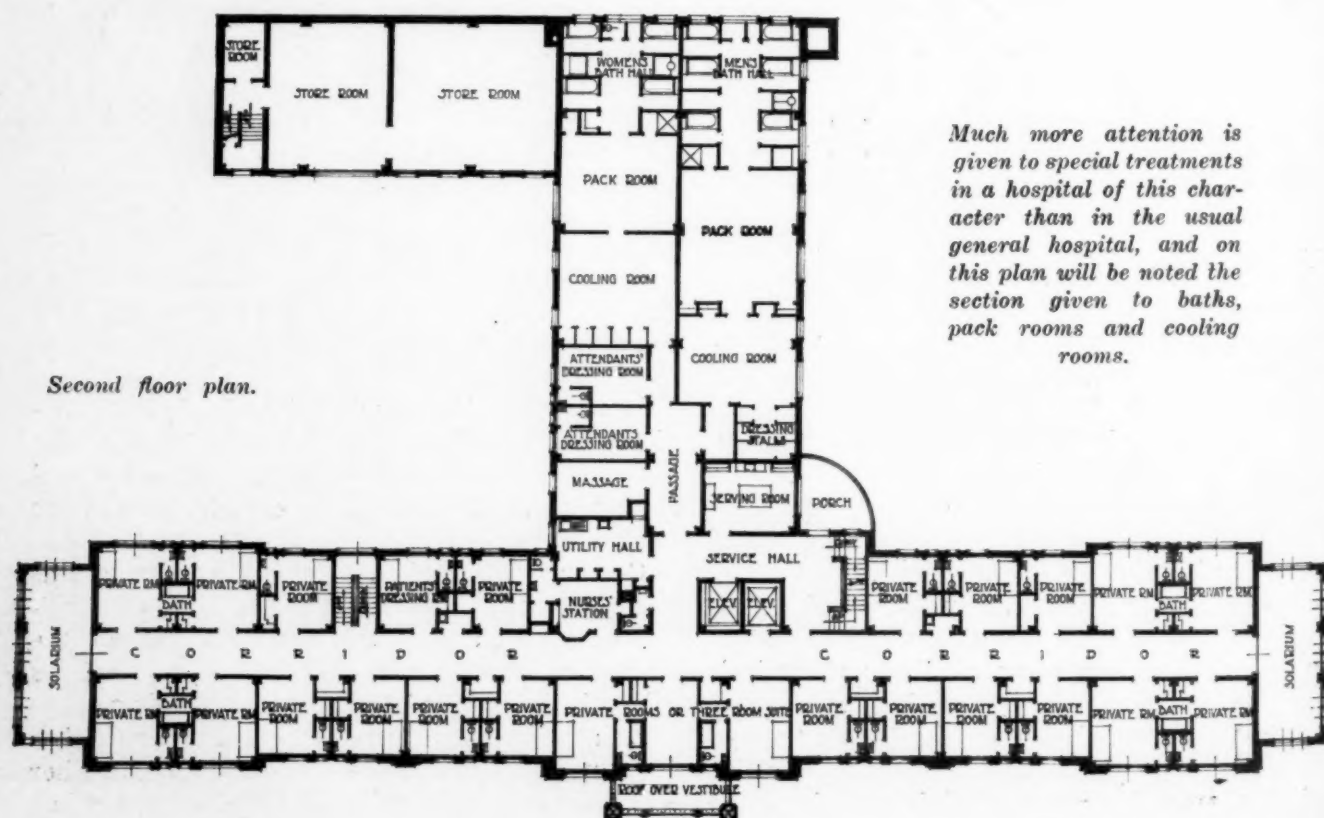


It is unusual to see a laundry adjoining the boiler and machine room, yet in localities where there is plenty of room the idea has its advantages. An excellent feature of this building is the solarium at each end.

In planning the entire building, the keynotes have been simplicity, efficiency and economy. The term economy is here used in its best sense, namely, "spending wisely."

The sizes and relations of the various units

were carefully determined, and nothing was left undone that could aid in developing a compact plan, without waste space of any sort, yet one that permitted of easy and efficient administration and provided the patients with every neces-



Much more attention is given to special treatments in a hospital of this character than in the usual general hospital, and on this plan will be noted the section given to baths, pack rooms and cooling rooms.



A group of the Sisters and nurses.

sity and convenience that might promote their cure.

Especial attention has been given to details, so as to reduce upkeep and maintenance costs.

All door frames, window sashes and finish of every description are of steel and are flush pattern, giving a smooth finish without molds or panels. Tile work and marble work are also flush with the plaster surface, and all corners and angles are rounded and coved. All cases, cabinets and lockers are built into recesses, so that there are no open spaces over, behind or around them.

The plumbing fixtures are of high quality and

are especially adapted to meet the various service needs of hospital routine and to withstand hard service conditions. All piping is of heavy wrought iron, except the hot water lines which are of heavy brass.

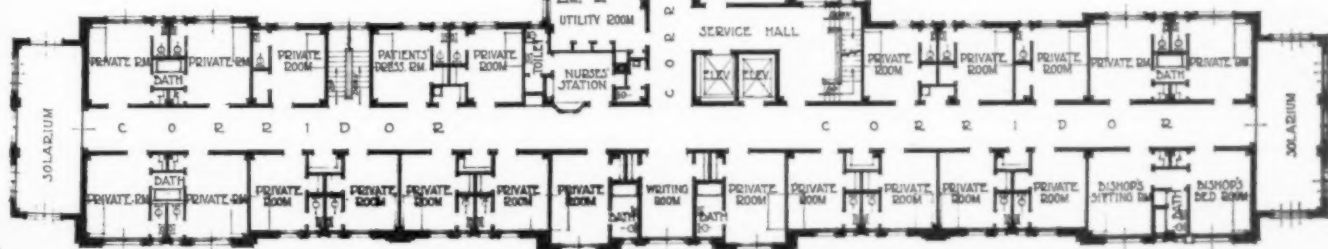
The elevators, electrical work, nurses' call system and telephone system represent the latest and most approved types for hospital work, and are designed and installed for convenient operation with minimum of maintenance.

All equipment in the main kitchen is also of the most improved type. Ranges and kettles are grouped around the vent stack, and fumes and vapors are collected in a large hood over this



Third floor plan.

Particularly interesting is the arrangement of dining rooms in their relation to the kitchen. Although located on the third floor there is no inconvenience of preparation or service.





The annex to St. Joseph's Hospital, Hot Springs National Park, Ark.

equipment, and are vented and discharged upward through a large duct. All floors in the kitchen department are a rich red quarry tile, and the walls have white glazed tile wainscots. Refrigerators and cases are set up on sanitary bases, and are furred in so as to present a perfectly smooth, neat and sanitary appearance.

There is a diet kitchen on each floor, which is self-contained and equipped to function separately from the main kitchen, if so desired.

The reception room and parlor, office and emergency receiving room are on the first floor. This floor also houses the laundry, boiler room, cold storage and refrigerating plant, which supplies the ice boxes throughout the building.

The massage, pack rooms, cooling rooms and bath halls of both the men's and women's departments of the bath house, where the United States Government thermal baths are given, occupy the entire back center wing of the second floor. Highest grade plumbing fixtures have been installed. The floors are of terrazzo, with six and a half foot white glazed tile wainscoting.

The north center wing of the third floor contains six dining rooms, and connecting serving rooms. These are for the bishop, guests, visiting priests, Sisters, graduate nurses and pupil nurses. The guests' dining room is beautifully paneled in red gum tree, finished in walnut. A feature of the priests' dining room is a reproduc-

tion of "The Last Supper," done in inlaid relief work and inserted in the walls. The office of the superintendent of nurses and the nurses' reporting room are also in this wing. The guests' writing room and a *de luxe* suite of two rooms are features of this floor.

On the fourth floor are the charity wards, a complete maternity department, a nursery and a *de luxe* suite of three rooms. All these departments will be fitted with modern equipment.

Equipment in the operating section is the best money can buy. In the operating suite are two major and one minor operating rooms, sterilizing rooms, x-ray department and a cystoscopic room, as well as a laboratory, a fully equipped pharmacy and a surgical dressing room. Each of the operating rooms is provided with private scrub-up and dressing compartments for surgeons, visiting surgeons and nurses, fitted with showers, lavatories and lockers.

A spacious roof garden for convalescent patients, with red tile floor, is a feature of the institution.

The service wing of the building contains, in addition to the kitchen, a completely equipped bakery, storage rooms and quarters for the help.

Other features of the building are the central location of the nurses' station and record room, the utility room, blanket and solution warmers, supply closets and an airing balcony on each floor.

Are We Meeting Our Patients' Social Needs?*

By RUTH EMERSON

Director of Social Work, University of Chicago, Chicago

THE prime consideration of the hospital is the care of the patient. On him are focused all its resources of personnel and equipment to restore him, so far as it is possible, to health, and to help him maintain health. The superintendent and medical staff are vitally concerned, therefore, with whatever may affect his treatment. Let us analyze the patient's needs from a social point of view and see in what ways the medical social worker can make it possible for the hospital to meet them. On the basis of such an analysis it should be clear whether or not the small hospital needs a social service department.

The small hospital for the most part is meeting the need of persons living in small communities. Often it serves a territory of several miles and offers the one haven for the sick in widely scattered districts. Many of its patients come from a distance, expect to remain a few days at most, have little or no knowledge of the duration of illness or the consequent period of convalescence, may never before have been to a hospital and have no understanding of its routine.

Family Adjustments Must Be Made

Even at the outset, before the patient is actually admitted, he often requires assistance. There was the mother with acute abdominal symptoms, who refused to enter the hospital until the social worker had telephoned the public health nurse in an adjacent town thirty miles away, and arranged with her to visit a neighbor and plan for the children to have their dinners daily with this neighbor, and remain until their father should call for them in the evening. This is not an isolated example of the family adjustments that illness frequently necessitates, and which must be made before the patient can begin his treatment.

Once the patient is in the hospital he is largely concerned with his present plight in terms of when he will get back to his accustomed duties. His interest in himself is primarily in relation to his social environment, and only in the second place is he interested in himself as a sick person.

Many a patient revolves in his mind such disquieting thoughts as these: "I cannot afford to be off my job a week." "I must go home tomorrow, the children cannot manage." "I do not believe the operation is necessary. I'll wait until I am sick again. They say the doctors operate just to learn what's going on inside of you." He mutely asks the hospital to consider these questions which are upsetting to him, but he refrains from mentioning them because to him they have no bearing upon his illness and are outside the field of the doctor or nurse.

What the Physician Should Know

Now, although he may see little relation between his worries about his job, or his home and his illness, we know that they have direct bearing on it and that an understanding of them is essential to his physician. In fact, the importance of such intimate understanding is stressed by physicians both in their practice and teaching, as evidenced in a lecture on the "Care of the Patient," by the late Dr. Francis G. Peabody¹ of the Harvard Medical School, in which he said to the medical students:

"The essence of the practice of medicine is an intensely personal matter, and one of the chief differences between private practice and hospital practice is that the latter always tends to become impersonal. At first sight this may not appear to be a vital point, but it is, as a matter of fact, the crux of the whole situation. The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it. Moreover, the circumstances under which the physician sees the patient are not wholly favorable to the establishment of the intimate personal relationship that exists in private practice, for one of the outstanding features of hospitalization is that it

*Read before the American Hospital Association, Minneapolis, Minn., October, 1927.

¹ Francis Peabody, M.D., "The Care of the Patient," reprinted from the Journal of the American Medical Association, March 19, 1927, Vol. 88, pp. 877-882.

completely removes the patient from his accustomed environment.

"This may, of course, be entirely desirable, and one of the main reasons for sending a person into the hospital is to get him away from his home surroundings which, be he rich or poor, are often unfavorable to recovery. At the same time it is equally important for the physician to know the exact character of those surroundings. . . .

"There are moments, of course, in cases of serious illness when you will think solely of the disease and its treatment; but when the corner is turned and the immediate crisis is passed, you must give your attention to the patient. Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment."

In the hospital the patient often feels that he is in a foreign country where he does not understand the language spoken around him, and where he thinks he cannot be understood. Often, too, neither he nor his family is articulate or appreciates the significance of much that to his doctor is both relevant and important. This is especially true of the kind of information on which the psychiatrist depends to reach his diagnosis and formulate his plan of treatment. The patient must, for the most part, therefore, depend on someone to give to his physician this picture of him as a social being, because even in the small hospital, where frequently he and his family are known, this friendliness and general acquaintance do not bespeak any accurate knowledge of facts.

Do Not Sever the Man From the Patient

Two tendencies in modern medical practice are placing the patient in somewhat of a dilemma. On the one hand is the physician who, we have said, wishes to know him in the setting of the work-a-day world; on the other hand is the hospital organization which robs him of his individuality and personality, and makes of him merely a "case." He is dependent upon someone within the hospital's organization whose first responsibility is to him, and who, mindful that the man and the patient are identical, will counteract the tendency of the hospital machinery to sever them. The medical social worker not only masters the machinery, but in addition helps to integrate the forces within the institution and have them centered on the patient who, of himself, is helpless to cope with them.

If the need of the patient for the medical social worker is apparent at the time when he first enters the hospital, when the diagnosis is being established and a plan of treatment outlined, it becomes increasingly evident as treatment progresses. Let us next consider the problems that confront him in his undertaking to carry out the doctor's recommendations. Is he self-sufficient in this field? The physician of yesterday who prescribed pills and powders asked little of his patient, but the doctor who, today, prescribes a change in diet and rearrangement of one's daily régime, calls both for intelligent understanding, perseverance and often for the surmounting of obstacles by his patient. The emphasis now placed on the part that the patient is to take in his own treatment is one of the striking changes in medical practice during the past decade. Janet Thornton,² Presbyterian Hospital, New York, has called attention to this in a paper read at the National Conference of Social Work in 1923, from which the following is taken:

How the Patient Can Help

"Think just a moment of a few of the attributes that present day medicine requires of the patient. I fancy even fifty years ago, before anesthetics and trained nursing were developed, that the attributes a patient needed most were courage and endurance. Today intelligence and perseverance can, I believe, be put at the head of the list. To carry out the prescription of a modern practitioner for the care and management of conditions like rickets, gonorrhea or diseased joints, requires a fairly high level of intelligence, not only on the part of the patient but also of his family. A high degree of perseverance is also required in many kinds of infirmities, where long, tedious treatments are called for, such as the correction of posture or the correction of any habit, whether of our muscles, glands or nerves. Syphilis is typical of certain conditions that require both perseverance and intelligence on the part of the patient. The treatment is unpleasant and often shows little result; it is long drawn out and frequent, and all the while the patient may feel no pain or disablement. The problems cited are old in medicine, but the part that the patient is asked to play in present day treatment of these problems is becoming greater and more rigorous. Wherever medicine is practiced, more and more participation is being demanded of the patient. At the same time, the patient is being individualized and studied as he never has been before. Two facts are recognized—that each applicant

² Janet Thornton, "Social Case Work Method in Health Work," National Conference of Social Work, 1923, University of Chicago Press, pp. 23-27.

presents a unique problem, and, to a far greater extent than had been previously realized, that there resides within the applicant the means for solution of his problem."

Most of us will perseveringly attempt to change our habits, or will try to arrange our affairs differently, only if someone makes clear to us the reason behind the proposed change and the possible benefit that may accrue. So that if we agree with Miss Thornton it becomes apparent that we need someone to interpret to us our rôle and to coach us as we learn to play it.

The Family Also Has a Part to Play

Sometimes it is not only to the patient but also to his family that the interpretation of the hospital and the doctor's plan must be made. This was evident in the case of a young man who, because of severe diabetes was a bed patient for several weeks, during which time his wife gladly went to work to help support their four children. When he was discharged he was advised not to work, to continue his diet and insulin, which cost a considerable sum, and to report to a clinic. He followed instructions faithfully for several weeks, but one morning returned to the clinic looking wan and with sugar in his urine—the good work of weeks undone. He told the doctor that his wife believed that he was quite able to work and was only shamming illness; that she said that it was his job, not hers, to support the family, and that she would not live with any man who would have cream for himself, let his wife cook special food for him and allow her to support him and the children. For several days, therefore she had been making arrangements to place the children with relatives, and leave him to shift for himself.

We can appreciate this woman's point of view. She had no understanding of her husband's condition or of what they might look forward to if he kept to his diet and continued to gain in strength. A simple statement would not, of course, have sufficed. It was only after a considerable period that she did make her adjustment and their family life went on more tranquilly. The doctor, dietitian and social worker each assisted in the interpretation of the situation, and through their understanding of both the patient and his wife helped them to see life as a whole.

The patient who is discharged against the advice of the physician is often an indication of failure on the part of the institution to understand him and to meet his social needs. Frequently he can be persuaded to remain if one can discover the real, not merely the apparent reasons why he wishes to leave, and can meet his

objections with a practical plan. All institutions attempt to do this, and when they fail it may be due to the way in which they sought to help the patient reveal his reasons and what lay back of them. Interviewing is an art, and never more of an art than in relation to a sick, troubled hospital patient. The medical social worker is expected to have skill in this art.

There are three questions that the patient always wishes to have answered but which he is seldom able to express for himself: "What is the expected outcome of this condition with treatment? What outcome must one be prepared to face without treatment? What are the essentials in this treatment?" The answers to these questions form the basis on which the doctor, the patient and the social worker meet. In this common understanding of the medical plan, obstacles that seem to the patient impossible to overcome, show in proper perspective. Often a course can be charted that will steer around these obstacles, but usually this depends on the patient having someone who will point them out to the physician in such a way as to prompt a modification of the original plan or lead to the outlining of a new course.

Discharged Patients Need Help

When the patient must surmount obstacles that lie outside his own character, he often needs assistance in reaching out and bending the resources of the community to meet his needs. A young man was discharged from a hospital, was told to return weekly for special x-ray treatment and was assured that after a few months he might go back to work for a time. He lived with his wife and two children in a small, isolated town fifty miles from the hospital, had no savings, no means of transportation, and naturally saw no way to continue his treatment. Obviously he needed the medical social worker who helped him make and carry out a plan so that he might get his treatment.

A child who had both legs amputated by a mowing machine received the finest surgical and nursing care in the community hospital. She went home to a devoted family and to neighbors eager to do anything and everything to help her, but what should be done?

Every now and again someone says that the physician in the small town is more like the old type of family physician; that he can pretty much do the whole job; or that the superintendent and the doctor in the hospital often know the patient and his family and have the time for a personal relationship with them. Often one hears talk of the friendly neighbors in the town or village and

the willing helpfulness of the village townspeople. I rejoice whenever this is so, but I contend that often the service that a patient or his family needs, requires more than a general acquaintance-ship, friendly feeling and well intentioned interest. Many times the general practitioner meets the needs of his patient; sometimes nevertheless he requires the specialist. In some situations a practical nursing attendant suffices; in others the skilled graduate nurse is needed. And so it is in the social field—the superintendent or the physician often meets the family's needs; at other times the social worker has a definite part to play.

Many times adequate treatment of the patient involves the hospital in the health problems of his family. This is obvious in the field of communicable disease, but is also of considerable importance in many other instances. A mother of three children was ill with pneumonia in the private ward of a small hospital for several weeks. Often her two boys, aged eight and ten, came to see her and were with her when her physician visited. Never once did he inquire about the health of the boys, although one was obviously a mouth breather, was pale and undernourished. The other child had a marked scoliosis and strabismus. Had the doctor been interested in the general health problems of his patient, the children might have been under care months earlier, and probably one of them would not have been out of school the next winter to have his adenoids and tonsils removed.

Social Worker Should Teach Health

While the patient is himself ill he is more conscious of health values than he may be ever again, more eager for the health of his family, readier to talk and plan about it. It is always interesting to note how frequently the medical social worker who seeks to meet the medical social needs of the patient becomes involved in health problems of other members of his family. She has the opportunity to carry the hospital's ideals of health education of each patient and of the community, beyond the bounds of the institution or the care of a single patient.

Occasionally someone says that a small hospital with rural patients has little concern with the problems of diet and right living. A study of the hygiene of persons living in the country will, I believe, disprove this belief. It is no less the responsibility of the small hospital to teach the hygiene of right living than of the large institution, although it may be from a different angle. It may even be of more importance because frequently the small hospital stresses its relation to the community and assumes a place of

leadership in all matters relating to the health of the community.

This is but a cursory review of the patient and his needs, but it makes clear that he cannot of himself meet the requirements of modern medical practice. It follows, then, that the hospital whose object is to give him adequate care, should provide the means whereby he may meet these requirements.

In hospital practice as in social practice the only sound way to approach the solution of any problem is through the careful study and analysis of the factors in it. On the basis of such a study one may build synthetically to solve the problem. Therefore I will not be drawn into a general conclusion that every small hospital must have a social service department, an organized method of meeting the social needs of patients in some hospitals and clinics, lest by so doing I commit myself to the wholesale production of medical social service departments.

Adapt Plan to Special Needs

One of the terrors that besets me in these days of organized education, organized recreation, organized this and that, is the tendency we have to adopt in wholesale fashion an idea or method that has proved satisfactory or adequate in a particular situation. It is so much simpler to accept the pattern without inquiry into its special uses, and without an analysis of our special needs, than to make such inquiry and analysis and then see whether the proposed pattern meets our needs or can be adapted to meet them.

I leave with the individual small hospital the responsibility to study and analyze its problems from a medical-social viewpoint, and then to evolve a plan to meet them. The extent of these needs will vary with the individual institution, and will depend primarily upon the type of medical problem that it is treating and the resources of the individual community.

I am critical of institutions that assume that they have met their social obligations to the patient by placing someone—anyone—in charge of social service, and I would withhold from an institution the right to use the name "social service department" until it has a qualified medical social worker on its staff. There is no official registration of medical social workers, as of doctors and nurses, but active membership in the American Association of Hospital Social Workers indicates that the individual has had both education and practice in medical social work. At present "social service department" is often only a label, because the staff is not equipped to practice medical social service.

How the Sisters of St. Francis Are Serving the Sick

By A. L. BOWEN

Springfield, Ill.

ST. JOHN'S Hospital, Springfield, Ill., has completed a \$400,000 construction program, making a total of about \$1,250,000 invested by the hospital in new buildings and permanent improvements in the last five years.

Springfield is a city of only 70,000 people, and the county of which it is the capital has only 110,000 inhabitants. Yet the community has so fully grasped the importance of modern hospital facilities and methods that it supports institutions having a total capacity of more than one thousand beds, and approves the expenditure of this large sum of money by St. John's Hospital, to widen the radius of its appeal and to make its operations more efficient and effective. It is estimated that at least three quarters of a million dollars

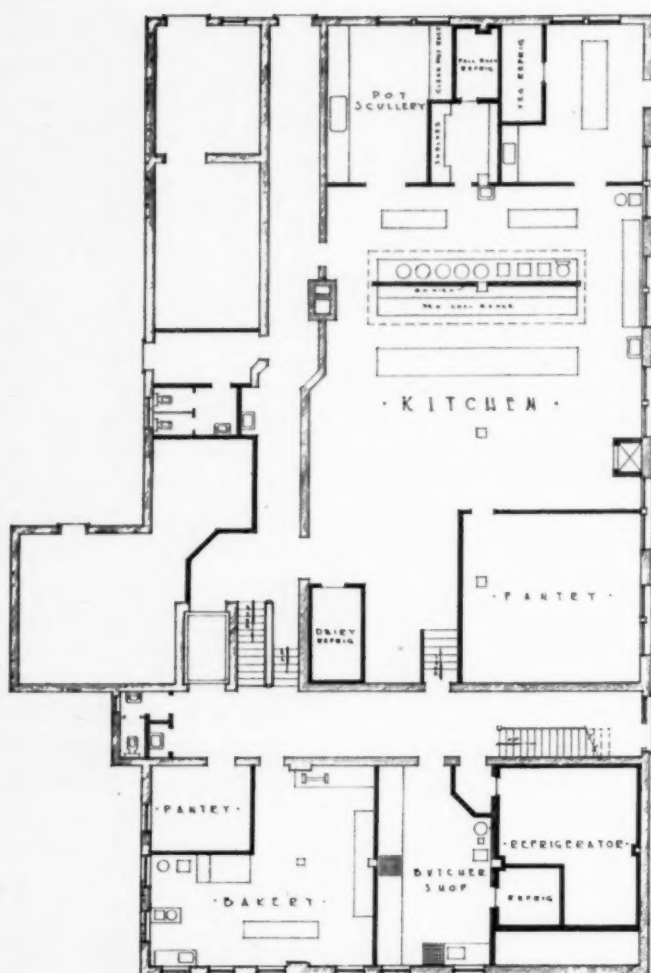
will be necessary to round out St. John's Hospital so that it may fulfill the ideals that have been conceived for it.

The \$400,000 spent this year has been divided as follows: a modern heating plant; underground tunnels, connecting all units of the extensive plant; new kitchen, bakery and refrigeration; new laundry; new dining rooms for employees of all classes; a contagious disease hospital of twenty-eight beds.

St. John's Hospital is the mother house of the Sisters of St. Francis, who operate from it fourteen hospitals in Illinois, Wisconsin and Missouri, and one recently opened at Tientsin, China. St. John's is slightly more than fifty years old. It has been the ambition of the Sisterhood to develop



Interior of chapel at St. John's Hospital Sanitarium.



Courtesy Helmle & Helmle, Springfield, Ill.
First floor plan, St. John's Hospital, Springfield, Ill.

there a model institution, in respect to plant, organization, administration, training, service and fees.

The hospital has two divisions. The city hospital occupies two large squares bounded by Mason, Seventh, Reynolds and Ninth Streets, and contains 557 beds. Seven miles in the country, on the banks of the Sangamon river, is St. John's Sanitarium, with 225 beds. Five hundred and fifty acres of land was purchased for the site and \$1,000,000 has already been invested in the buildings.

The city hospital and its sanitarium accept all but disturbed mental cases. Practically every specialty is practiced, both in the hospital and in the free dispensary.

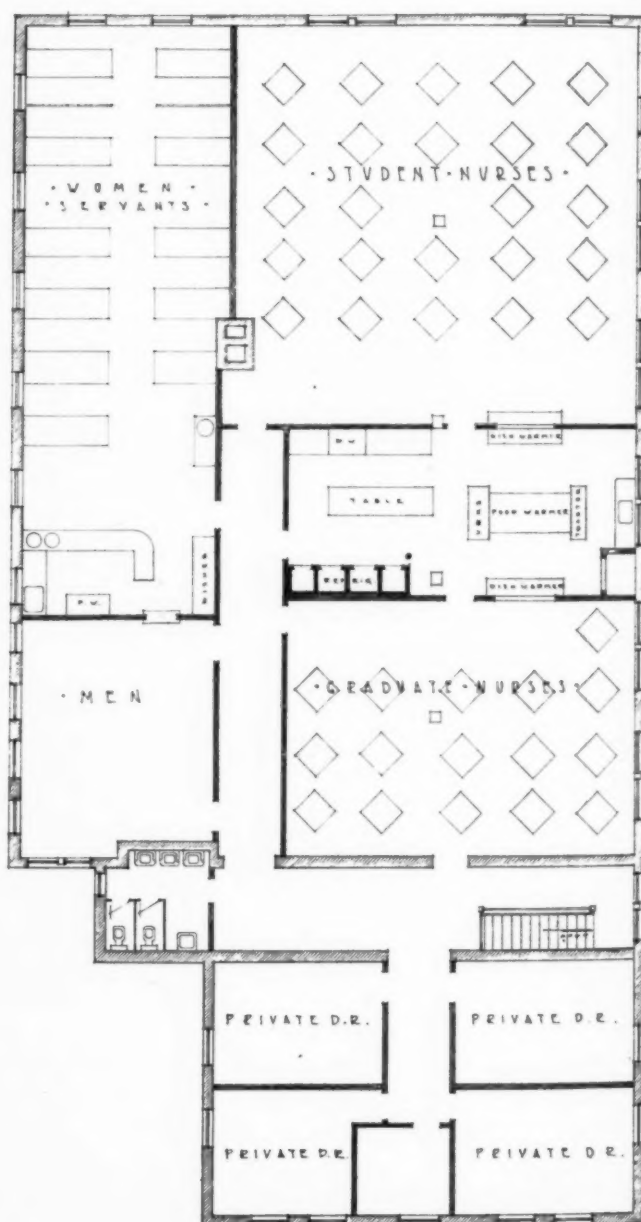
Two years ago an immense unit for maternity and children's cases was opened. There are four operating rooms for major surgery, with modern equipment. There are also departments for physiotherapy, electrotherapy and hydrotherapy, as well as numerous laboratories.

The new power house contains three 250 horse power water-tube boilers, with berth for a fourth when it may be needed. The furnaces are supplied with chain grates, automatic stokers and all

modern appliances for measuring heat, regulating drafts and gauging steam and hot water. Coal is carried by endless chain to overhead bunkers, and ashes are delivered to the wagons on the outside by the same method. The building is large enough to accommodate machine, cabinet, carpenter, paint and print shops. Quarters and a club room for the single male employees of the hospital are in this building. This heating unit cost \$150,000.

The power house is near the northeast corner of the site. From it a large tunnel bisects the hospital area to the west boundary of the grounds, with laterals to serve all units.

The old power house which stood in the center of the two blocks, has been almost wholly removed. Portions of its walls have been incorporated into the new laundry, kitchen and dining



Courtesy Helmle & Helmle, Springfield, Ill.
Second floor plan, St. John's Hospital, Springfield, Ill.

room, which are large enough to serve both patients and employees.

The new dining rooms are on the second floor, above the kitchen and bakery. There is a separate dining room for each class of employees. Floors are of terrazzo. Walls are of glazed brick and tile to the height of eight feet, with plaster above. Modern lighting fixtures, decorated walls, attractive furniture and curtains make inviting dining rooms. Cross ventilation is provided, with additional facilities through the roof. All refrigeration is new and of the latest type. Storerooms for flour, vegetables, fruits and meats have been laid out on liberal dimensions, and are easy of access to both cooks and bakers. They may be reached by tunnel from any point in the institution.

Local Conditions Govern Planning

How local conditions govern the planning of all service departments of a large hospital is graphically illustrated in the kitchens and dining rooms of the new unit at this institution. As has been stated, the building has been refashioned out of an old structure. The first floor level is slightly above grade. All food is moved on trucks from the kitchen to the basement, by means of an electrically operated elevator. Here the carts are sent in all directions through corridors, to the various dining rooms and wards, located on the three square blocks. Automatic push button controlled dumb-waiters lift the carts to serving kitchens on each floor of each building, where the food is transferred to serving kitchens for ultimate distribution.

The floor over the kitchen contains the dining rooms for various grades and classes of employees—one for graduate nurses, one for student nurses, one for female help and several smaller rooms for special uses. The Sisters of the Order of St. Francis, who operate the institution, have a refectory in their convent. A portion of the basement of this kitchen building has been excavated for the refrigeration and ice making machinery and for storage.

The layout is adequate for the present needs of 550 beds, and meets the various special requirements of the hospital. It will be noted that no precautions are taken to protect food supplies from waste and theft as the hospital is administered by a Sisterhood and therefore such precautions are not necessary. Another innovation may be seen. Generally an institution as big as this one has its own butcher shop and has refrigeration adequate for the storage of meats in large quantities, to be followed by its preparation and conveyance to the kitchen. The reverse is the practice here. Meat is delivered in small quantities, is immediately

prepared and is placed in a refrigerator for the brief period until it is needed.

The contagious disease hospital occupies a detached, fireproof unit, entered from Reynolds Street. It has been financed by the clearing house banks of Springfield, which have loaned \$100,000 for construction, on the guaranty of the city and county to pay the interest for five years, after which the hospital will assume the whole burden. A third floor may be added when needed, to double the bed capacity. This building is so arranged that it is possible for friends to see and communicate with patients without danger of infection or contagion. A chapel has been provided for public funerals, and it can be entered from either the street or the corridor. Provision has been made for postmortem examinations of contagious disease cases, with a small amphitheater for spectators. Ingenious arrangements of rooms and service safeguard the nurses and the public when their day's work is done and they wish to leave the institution.

Only a small area of these two blocks remains unoccupied. The future contemplates an auditorium on this corner, where public health lectures and demonstrations for the public and for professional men may be given. It is also planned to provide prenatal care and instruction in this unit.

The hospital has been so crowded during recent months that future building plans are to be modified. Instead of erecting new quarters for employees and a new nurses' home, it will probably be necessary to remove the oldest ward sections, which are three stories in height, and replace them with an eight-story structure of modern design.

School Maintained by County

The sanitarium division contains two hospitals, one for tuberculous patients and one for crippled children. The former has accommodations for 160 patients and the latter for sixty-five children. The county supplies a teacher and maintains a free daily school for all grades. Children are admitted from all parts of the state, the county paying the small fees when the family of the child is unable to do so.

The sanitarium has its own heating plant, its own dairy and a tested herd, which supplies sufficient milk for needs of the institution.

The architectural center is the chapel, a handsome Italian-Romanesque structure, from which the institution branches to the north and south. Here are also the house for novitiates of the Order and a home for Sisters. The program of extension includes an addition to both the tuberculosis and the children's hospitals, a fifty-bed

unit for chronic medical cases and a unit for nervous and mental cases.

St. John's and all the hospitals under this order are operated as open institutions. They have no medical staffs and do not assume any responsibility for medical service. Any member of the county, city or state medical society in good standing may practice in them, on agreement to observe their rules and regulations.

St. John's enjoys the services of 150 Sisters. There are 275 employees, making a total of over four hundred. The training school meets the requirements of the state department of registration and education and is also accredited in the State of New York.

Provides Care for the Working Man

"These hospitals and their Sisters," said Father J. C. Straub, the director of the Sisters, "have one simple policy—to provide service for the sick and suffering, no matter what their ailments may be, at fees within the reach of the working classes. The very poor, the public takes care of. The rich can care for themselves. For that great, intermediate class, especially the man on daily wages, they desire to give service that will not pauperize, humiliate or degrade. Such patients may enjoy the best we have at a price they can pay, without crippling themselves for years ahead, and they may leave with their heads erect, conscious they have not been the objects of charity in any sense of the term. St. John's is able to do this through the sacrifices and energies of the Sisters who receive no compensation for their time or labor.

"They have general fundamental policies for the administration of all fourteen hospitals. St. John's is their headquarters. Each hospital does its own purchasing, as far as perishable foods are concerned. Each one makes its own minor repairs. Clothing, linens, equipment of all kinds, canned goods, flour and similar supplies are purchased on contracts covering the needs of all. We keep the accounts and books here in Springfield upon standard forms. We watch fluctuations in cost from month to month. All buildings and major repair work are authorized and supervised from the mother house.

"Our Sisters make tours of investigation to learn new methods and to acquire new ideas. What they learn in this manner is communicated to all in the Order through a system of schools of instruction.

"Our project in China has been very successful. Tientsin is a city of 800,000, with inadequate hospital facilities. Our first unit comprises forty-eight beds, operating rooms, laboratories and other essentials."

How Reading Hospital Greet Its Patients

Every patient on entering the Reading Hospital, Reading, Pa., is presented with a pamphlet entitled, "A Word of Greeting." The object of this, according to William M. Breiting, superintendent, is to acquaint the patient with the hospital and its facilities, and to make him feel at home, so that the hospital will appear as a haven of refuge rather than a place to be feared and avoided.

The opening paragraphs of the pamphlet are enough to aid in relieving the patient from any nervous strain which the fear of entering a hospital might have instilled in him. They read as follows:

"The Reading Hospital is to be your home for the next few days and on behalf of our ninety nurses and 100 employees we wish to extend to you a cordial welcome.

"We want you to feel at home. We pledge ourselves to do everything in our power to make your stay pleasant, and you can depend on us to cooperate with your doctor in every way possible to help you to a complete and speedy recovery."

Then follows a list of conveniences offered by the hospital, such as the barber and beauty shops run by the hospital, notary public service, occupational therapy department, social service department, cafeteria service for friends and relatives, free stationery, electrotherapy and hydrotherapy treatments and refreshments for visitors. Many of the hospital's departments are described and patients are urged to make use of them. The responsibility of the hospital in the care of the sick is made clear through a list of rules and regulations regarding visitors, entertainment and the employing of special help and the use of special apparatus. Rules regarding the payment of bills are explained, so that the patient, at the time of entrance may know just when his bill will fall due, and approximately what the amount of it will be.

Navy to Build Hospitals in Time of War

The United States Naval Medical Department, having learned from its experiences during the World War that in time of a national crisis the facilities of government hospitals are bound to be overtaxed, has made plans which, in case of war, call for the erection of a number of semiportable hospital buildings.

The main object of these plans, according to A. B. Montgomery, chief pharmacist, United States Navy, is to relieve the civil hospitals from the necessity and responsibility of caring for government cases, whereby they reduce their capacity for service to the public. Other objections to the use of public hospitals are that their operation cost is considerably greater, and that it is hard to control men used to military discipline in such an institution.

The buildings, which will be constructed in units, each unit being thirty-two feet long and twenty feet wide, can be made in any desirable size. Each unit can accommodate about ten patients, so if forty patients is the desired capacity for the building, four units will be used. Two rooms in each building may be partitioned off for use as private rooms, diet kitchens or closets. In warm climates the buildings may be constructed of screen wire and canvas, while in the temperate climates wooden structures can be used.

Correct Those Wrong Ideas

By JOHN A. McNAMARA

Executive Editor, THE MODERN HOSPITAL, Chicago.

THE greatest evil that the hospital superintendent has to overcome today is misinformation. From a great variety of sources, through a great divergence of motives and because of a vast amount of ignorance come the statements that hospitals are charging too much, that they are badly managed and that superintendents are inefficient.

As is the case with any plausible lie, the sensational newspapers avidly grab at such statements and they are usually twisted and turned, so that finally the public is gravely informed that hospitals are perfect hell holes of waste and wanton extravagance. Newspapers cannot be blamed for seeking the sensational or the unusual, but the source of the information not only can be blamed but should be disciplined, because by an utterance based upon total ignorance of the subject or upon some one isolated instance, they may break down the work that has been done in the improvement of hospitalization during the past fifty years.

Gross Misstatements

Not so long ago a doctor made the statement that hospitals were poorly managed and his say-so was quoted from one end of the country to the other, recurring from time to time in editorials and comments in magazines for general distribution. His remarks were given credence, although he is not now and never has been a hospital administrator, and his statement was not based upon one single fact. He wanted free advertising and he got it, even if it cost thousands of dollars to the hospitals of the United States that he so maliciously maligned.

In the Mid West a physician known for his skill as a man of medicine, said that hospital charges were exorbitant, that nurses were, in effect, robbers for charging fifty-eight cents an hour, approximately the pay of a fairly competent hod carrier. He was absolutely wrong and obviously unfair to two of the factors that have enabled him to become one of our good physicians, but the ever alert newspapers pounced upon this misinformation with avidity.

Many of you heard the absurd and baseless assertions that were made on the same subject at the meeting of the American Hospital Associa-

tion. To date not one of those who yell the loudest against the hospitals has offered one bit of admissible evidence, not one of these men of science has dealt with facts, and it might be added that not one of them is connected actively with a hospital staff or he would have known better.

Let us see just what we are charging for keeping the community in good health and keeping the death rate down to less than 5 per cent.

There are approximately 120 million people in the United States and it is estimated that ten million of them pass through the hospitals every year. The average citizen therefore may expect to visit some institution once every twelve years, for a period of twelve days, which is the average length of stay in most hospitals. If he should pay as much as \$10 a day for his hospital room and \$10 to his physician every day he was in the hospital, and \$60 for a special nurse for part of the time he was in the hospital, he would have spent \$300. If he is an average citizen he is the head of a family of four, therefore he may expect to meet an illness bill of \$300 every three years. This makes his budget \$100 a year or just exactly the price of taking the family to the movies once a week, or buying 400 gallons of gasoline for the flivver to go a distance of 10,000 miles, or about half the price of his wife's fur coat or any one of a variety of things that are after all rank luxuries, yet which are paid for willingly and with no thought that the price is too high. The average charge for hospitalization in this state is about \$5 a day, or the same as you pay for a hotel room without food, special diets or nursing care.

What Our Survey Proved

Is the cost too high? Are we charging our patients exorbitant rates? Are hospital administrators wasters of public funds, and by public funds I mean those appropriated by the government, state or municipality and those contributed by philanthropists? Have conditions reached the point where hospital service is so expensive that people can no longer go to hospitals for treatment?

After a conference with several of the leading hospital authorities of the country it was decided that before a positive "no" was given to all of

these questions, we should do a little investigating ourselves.

Taking 1913 as our index we called up four of the largest hospitals in Chicago: Presbyterian, Michael Reese, St. Luke's and Wesley Memorial Hospitals. All of these four do an abundance of free work, none of them receives grants from the municipality or state or government and all of them pay their executives adequate salaries. In short, they are typical big city hospitals doing excellent work and handling a large number of cases daily. Here were the startling figures at Presbyterian Hospital:

Costs Increase; Charges Do Not

In 1913 the per capita cost was \$2.83 per day; in 1926 the cost had risen to \$6.65 or 135 per cent. In 1913 Presbyterian Hospital charged for its ward beds \$2 a day, while in 1926 the charge for the same bed was \$4 or an increase of 100 per cent. The charge for private rooms in 1913 ranged from \$4 to \$8 per day, while in 1926 the charge for the same accommodations ranged from \$6 to \$10 per day, or an increase of 33 per cent. This averages an increase in charges of 66 per cent, against an increase of 135 per cent in costs, or less than half. While prices of every commodity have been soaring the charges to the patient have increased only 66 per cent. Using 1913 as an index the dollar today is worth less than seventy cents, and wages for all classes of labor have reached the high point of approximately 170 as compared with 100 in 1913.

This tells but half the story, however. In 1913 in Presbyterian Hospital the average length of stay per patient was fifteen days; in 1926 the average length of stay was less than twelve days, so whereas the patient with the highest priced room in 1913 paid for his fifteen-day stay \$120, in 1926 the patient using the same room at \$10 a day for twelve days has a total of \$120—exactly the same.

If we stopped there we would show that there has been no increase at all in the charges to patients over a period of thirteen years but we have not taken into consideration the increase that has been going on for special treatments, or what is generally termed special charges. Investigation brought out the fact that if a patient had all of these special services his extra bill would not be more than \$50 additional, and most patients do not have a special charge bill of anywhere near that amount.

So up to this point the investigation of this small group of big city hospitals reveals the following facts: Costs have increased 135 per cent; charges have increased a maximum of \$50 or ap-

proximately 42 per cent due to special charges; patients have been returned to society three days earlier than previously, thereby causing an economic saving to industry of approximately \$15 represented by the average earning power per man. If this can be logically deducted from the increased cost, the increase is but 29 per cent.

A study of seven hospitals in the state of Pennsylvania was made: Braddock General Hospital, Easton Hospital, Hamot Hospital, Erie, Harrisburg Hospital, Jefferson Hospital, Philadelphia, Presbyterian Hospital, Philadelphia and Wilkes Barre General Hospital. The figures obtained were remarkably low. The average cost per patient in these institutions in 1913 was \$1.98 a day. This cost has increased to \$4.41 in 1926 which is 223 per cent. Ward charges in 1913 averaged \$1.68 per day, which was less than cost, while in 1926 the ward charges had advanced to an average of \$3.15, still less than cost, and the percentage of increase has been 188. In 1913 the average per diem charge for private room was \$5 and in 1926 it was \$9.07. In both cases this is the highest price charged, and it is thrown slightly out of proportion by the inclusion of the *de luxe* rooms of the two Philadelphia hospitals. The percentage of increase is 181 per cent.

So here we have a similar picture to that of the Presbyterian Hospital in Chicago. Costs have increased 188 per cent and private room prices have increased 181 per cent. Extending the comparison to Presbyterian Hospital, Chicago, we find that the average stay per patient has dropped in these seven hospitals full four days. As an example let us take the hospital at Easton.

What Has Happened in Easton

If a patient had taken a private room here in 1913 at the highest price, \$4, and stayed the average length of time, which was eighteen days, his bill would have been \$72. If he took the best room in 1926, which cost \$7, and stayed the average length of time, he would have a total bill of \$70 or \$2 less. That certainly doesn't look as if there had been any marked increase in the charges to the patient. If he had been a ward patient the contrast is even more marked. In 1913 he would have paid \$2.75 for a bed or a total of \$49.50; in 1926 he would have paid \$3.25 a day or a total of \$32.50, which is \$17 less. That certainly doesn't look as if the patient of moderate means were being badly imposed upon. When it is also considered that wages have advanced approximately 70 per cent, that standards of excellence in hospital service have vastly improved, that the death rate is undeniably lower, it is no stretch of the truth to say that in Pennsylvania

at least the hospital patients are getting more than their money's worth in its institutions.

Can any of you name one other line of endeavor that, in face of the rising costs of administration, has been able actually to reduce prices through more efficient methods, a tightening of business administration and a closer application of economic principles? And can you name any other line of endeavor that has come in for such hearty abuse and misrepresentation at the hands of the uninformed and the unscrupulous?

What Statistics Show

It is always interesting to compare hospitals with other public or quasi-public institutions and recently the U. S. Department of Commerce made public a study of costs in 146 cities of more than 30,000 population, of schools, health departments and hospitals, from a tax payer's standpoint. The report shows that there has been an increase in public school taxation of 207 per cent since 1916, an increase of 156 per cent in health and sanitation departments and an increase of 114 for charities and hospitals, including correctional institutions, by far the most inclusive classification and by far the smallest increase.

Isn't it about time that some pressure were brought to bear to silence those who spread the lie about high cost of hospitalization and lack of business acumen of hospital administrators? When we think of the vast improvements that have been made in the hospitals in the United States during the past fifteen years, and the improvements that are contemplated for this billion-dollar industry, when we think of the wide public acceptance of hospitals today as compared with fifteen years ago, are we not justified in denouncing our detractors in the most vigorous terms that we may call to our command?

The hospital superintendent's life is one of sacrifice. Any one of you could earn vastly greater sums in almost any line of business you might care to enter. Yours is no eight-hour day with time and a half for overtime. Yours is a twenty-four hour day, and the responsibility that you have assumed is the protection of the lives in your community and the health of the community, and the general well-being of every man, woman and child within that community. You are working not for great profit but for the pure joy of benefiting the place where you live, and by any analysis of the facts involved you are doing a good job. Yet in the face of this there are those who will blatantly say that you are inefficient, unbusiness-like and your charges are too high.

There is but one answer to their fictions and that is fact. There is but one way to silence their

generalities and that is with specific information, and it is yours to command if you will make a study of your own records in your own hospital.

Permit me to close with these sentiments from an article by Frank Chapman in the October issue of *THE MODERN HOSPITAL*:

"Hospitals are not inefficiently managed. Service for service and cost for cost, hospital operation throughout this land will compare favorably with that of any type of activity that is in any measure comparable. Hospitals have not increased their cost of operation out of proportion to the natural upward trend in cost of living. Hospital charges are not out of proportion.

"It seems that we who are responsible for the operation of hospitals should change our own mental process just a little and should cease to be apologetic for our hospital charges. We should actively combat, through every means in our power, this growing feeling that hospitals are overcharging; that hospitals are inefficient."

Hopeless? No, Just Misunderstood

An article appeared in a recent issue of the *Welfare Magazine* entitled "Restoring the Mentally Sick," in which the author described the method employed at the Chicago State Hospital, Dunning, Ill., in dealing with mental cases from the time of entrance to the time of discharge. The great amount of care, sympathetic understanding, untiring and loving patience, and skillful guiding of minds and hands necessary in the cure of these unfortunates were also described.

When a patient enters the hospital he is given, first, a thorough physical and mental examination. When his case has been diagnosed, if it is decided that he needs occupational therapy, the treatment in this department begins at once. The work in this department is divided roughly into three classes: habit training, kindergarten and occupational work proper.

The lowest type of patient is sent to the habit training department where he is taught the elementary points concerning the care of the body and clothing. Some of the patients are inclined to be destructive, and want to tear their clothes and break anything they lay their hands on. Their personal appearance is slovenly. It is necessary, then, to teach them to keep their clothing in order, brush their teeth, comb their hair and keep their hands and faces clean. All of this requires time and patience, and above all it requires understanding and study of the individual. It is in this department that constructive ideas begin to replace the destructive ones.

When a patient in the habit training department has progressed to a certain extent he is advanced to the kindergarten department. The work taught here corresponds with the lessons of kindergarten pupils, four or five years of age. The women are allowed to weave cloth with which they make rag dolls or pillows, and the men cut up brightly colored paper with which they decorate bottles to be used as flower vases. In short, they are taught the fundamentals of constructive work and their minds begin to absorb constructive ideas.

Time, patience and training combined are bound to bring results.

Do You Want to Improve Your Collection System?*

By A. B. BUCKERIDGE

Pittsburgh, Pa.

IF THE average retail store ran its credit department like the average hospital, the increase in bankruptcies would cause a senatorial investigation.

Even the most liberal installment store conducts some kind of a credit investigation on applicants for credit; and its follow-up on collections is systematic and sure.

While the hospital cannot investigate in the first place in the way the retailer does, it can take a page from the retailer's book and use similar methods of collection.

In the first place, the merchant has an understanding when an account is to be paid. When the account is opened, he informs the customer at what date it must be paid. The terms are clearly understood, even if the arrangements call for weekly or monthly payments over a year or longer. All of you have personal accounts at stores that exact payment on the tenth of the month. You also have accounts at places where no terms are mentioned and you feel you are not obliged to pay "right on the dot."

When, as occasionally happens, you do not have enough money to pay everybody in full, you know what happens—the stores that have made you understand that prompt payment is necessary get their money and the others take their turn, or receive only part payment.

Also consider the bank. When you sign a note you know that payment is to be made in thirty, sixty or ninety days. You adjust your finances so as to meet your obligation on the specified date. Incidentally, the bank does not hesitate to remind you of it a few days before the money is due, and as you know that is the bank's regular procedure you heed the warning and do not feel offended.

When hospitals adopt a uniform manner of extending credit by advising patients of their terms, then the first step in safe and sane credits is reached.

The next step of a progressive retail store is to notify the customer when the time for payment has passed. For instance, if you have an account

that is payable in thirty days and you do not meet the obligation at that time, about the forty-fifth day, you receive a nicely worded, gentle reminder that possibly you have overlooked the payment, and the terms are called to your attention.

At the end of sixty days, the reminder is a little more pointed.

At ninety days, the collection procedure begins in earnest.

At this stage the hospital can take advantage of its membership in the credit bureau. After letters have been sent calling attention to the need for prompt payment, a stronger message is needed, and the matter of advising the debtor of the necessity of maintaining a good credit standing is in order.

How to Get Action

The hospital can use a truthful threat in telling the person that unless the account is paid, it will be necessary to notify the credit bureau, whose files are available to the merchants, business and professional men of the city.

When a debtor receives a threat that such and such a thing will happen to him if he does not pay, and either because of unwillingness or inability he does not or cannot pay, he awaits the fulfillment of the threat. If nothing happens he begins to wonder whether he is being "kidded." The next time a threat is made, he ignores it and finds that the game of bluff can be successfully played by creditors.

The unfollowed-up threats to collect accounts have produced more "deadbeats" and devitalized more collection departments than anything else.

This applies also to hospitals that turn their accounts over to collection agencies of questionable reputation. These agencies use every kind of threat imaginable, which they fail to carry out. They insult the debtor in every way possible, and leave behind them a mob of delinquents who are "frothing at the mouth" because the account has been handed over to such an unscrupulous agency.

But when the hospital can tell the patient that, as a member of the credit bureau, it is required to list with the bureau the records of all accounts

*Read at the meeting of the Hospital Association of Pennsylvania, Pittsburgh, March, 1928.

not paid promptly when due, and can suggest in a helpful manner that if payment is made at once the patient's name will be omitted from the list, then the hospital is using a means of collection that is painless, effective and helpful to the patient.

Incidentally, when the patient does not pay, the hospital reports this fact to the credit bureau for the protection of its other members. Investigations conducted by credit bureaus have shown that the people who do not pay the hospital do not pay the grocer, the meat dealer, the department store, the physician or the dentist.

What Collection Letters Should Tell

Every credit bureau has a series of collection letters that are sent out for members at a low cost, and which the hospital can use with good effect.

The first letter tells the patient that each member has to send the bureau a list of ratings at regular intervals, which are placed in the bureau files. The bureau points out that the account mentioned is past due, and should be paid at once to avoid an unfavorable report.

The second of the series calls attention to the fact that the first letter has not been acknowledged and that no payment has been made on the account. It points out that every credit grantor is entitled to one of two things—either that the debtor pay the account or that he explain why it has not been paid. The letter closes with the statement that the bureau is not a collection agency.

You can see that these two letters do not contain anything that might offend the person receiving them. In fact bureau records show that many persons write or telephone the bureau and thank it for calling attention to the account—with the usual alibi that they had never received a statement of the amount owing and thought it had been paid.

The third letter is for the class of person who does not respond to gentle treatment or hints. It tells him that unless he pays the account within a specified time a statement to that effect will be recorded in the bureau's files, and will be available to practically every merchant, business and professional man in the city or county, which doubtless will result in his being refused further credit.

When the letters do not bring about a settlement of the account, then if the bureau handles collections, it offers the best chance of recovery. In case the local bureau handles credit reports only, it is best to have a responsible collection agency handle the accounts; or to make arrange-

ments with a reputable attorney to take charge of them.

While a hospital should secure credit reports on patients, there is one time when it always should call the bureau. That is when an account is more than thirty days overdue. By getting a report from the bureau it is possible to find out whether the person has the willingness and ability to pay. A person may have lots of money, own his home and hold title to an expensive automobile, but unless he has the willingness to pay, he is an unprofitable customer. He also may have the willingness to pay, but unless he has a good position, money in the bank or other resources he cannot meet the obligation, no matter how much he may want to.

If the patient is in good standing and has always paid his bills promptly, then you know that there is not much necessity for prompting him or continually reminding him of the account. But if he owes everybody in town, it is not necessary to dilly-dally around. If he has any money he will pay the most persistent collector. If you do not follow him up closely he may move and your chances of finding him are remote.

If the bureau's investigation shows that the patient is in desperate circumstances, owes more money than he can possibly pay in a few years, as is the case in countless instances, it is better to cross the account off your books and charge it to charity, than to waste your time in throwing good money after bad or pressing the miserably unfortunate.

Do Not Postpone Collections

The greatest mistake made by hospitals is that they wait too long before they start collecting. It is always hard to collect for a bill long delinquent; in fact it is well known that the older the account the harder it is to collect.

Get the patient before he has time to forget the bill or incur more pressing obligations. Collect the money before he moves out of the vicinity, city or state. Collect it yourself before you have to pay a large commission as a result of your own carelessness or lack of follow-up.

Hospitals should cooperate with credit bureaus because of the moral support they afford. When people know that unless they pay their bills promptly the information will be reported to the credit bureau, which will result in their being refused further credit, they will naturally be more careful in the obligations they incur.

Hospitals should contribute to advertising funds of bureaus and credit associations in order to educate the public through the printed word of the necessity of prompt payment.

California's Sunshine Brings Happy Smiles and Joyous Health



Courtesy Los Angeles Tuberculosis Association

HOSPITALS generally have been quick to grasp the value of sunlight in the treatment of many diseases, and remarkable results have been achieved through the influence of the sun's beneficent rays, especially in cases of tuberculosis. Here are shown children regaining or building up their health through heliotherapy, while at the same time they pursue their studies.

How Occupational Therapy Is Used in the Mental Hospital*

By MABEL A. M. BOND

Director of Occupational Therapy, Colorado Psychopathic Hospital, Denver, Colo.

IN PSYCHOPATHIC hospitals occupational therapy has been found to be of great value. In France, as early as 1791, Pinel liberated the mental patients and gave them something to do.

Two therapeutic measures have been used in the past for treatment of mental patients, namely, work and hydrotherapy. Today we have occupational therapy and hydrotherapy as definite forms of treatment for various types of convalescent patients. Canada was the first country to organize occupational therapy.

Occupational therapy is a method of healing by means of occupation. It comprises any activity, mental or physical, definitely prescribed and administered for the purpose of contributing to or hastening recovery from disease or injury. Therapy means treatment for a definite end. Occupational therapy is not a hit-or-miss affair of keeping the patient busy, but a definite therapeutic measure for specific ends, the needs being sometimes mental, sometimes physical, sometimes social. In the old days patients were kept employed with work that was waiting to be done. Today the work is chosen to suit the need of the patient.

The Colorado Psychopathic Hospital, Denver, Colo., has a bed capacity of eighty. Through this hospital passes an endless stream of patients of all types, afflicted with various mental and physical maladies. The average stay of a patient is from six weeks to two months. A few remain longer, and when a patient shows marked improvement, it is the policy of the hospital to advise him to remain until his recovery is complete. It is the duty of the occupational therapy department to meet the problems of these changing groups and plan daily programs for them.

Daily Programs Are Planned

At the Colorado Psychopathic Hospital, the director of the occupational therapy department lectures during the year to the relatives of the patients. At these lectures articles made by the patients are exhibited. Lectures are also given to the student nurses.

A tactful, sympathetic and understanding aid should be able to awaken the interest of the patient on his arrival in the hospital. The aid must have some insight into the patient's varied interests. If possible the doctor should introduce the patient to the director of the occupational therapy department, and impress upon the patient the advantages and privileges of occupational therapy. The aid should be courteous and should show respect for the patient as an individual. Each patient is an individual problem.

Doctor Should Issue Prescription

A definite prescription from the doctor for each patient is filed in the occupational therapy department. The prescription generally gives the diagnosis of the patient's illness, and some information regarding his mental traits, characteristics and former occupation. It also indicates the varied reactions of the patient toward work, and it should be carefully checked each day by the aid. This record is kept on file in the department and is of great value to the medical staff in showing the patient's progress.

A liberal appropriation must be available for necessary raw material for the occupational therapy shop and for ward equipment. We endeavor to make useful as well as beautiful articles. We have good models and designs to show the patients, and in this way their interest is aroused by seeing the finished article. Each new article is carefully planned as to use, design, color and material. This not only makes the article salable but useful to the hospital. The work accomplished in the department is determined largely by the type of patient. We make something that can be finished quickly, or something that can be passed from one worker to another without too much detriment to the article. On the whole, the work should be a personal project for the patient or an article that the patient may enjoy making for the hospital, rather than an article of market value. Most of these articles are sold to the patients for the cost of the materials. The remaining articles are exhibited and sold. The receipts from the sales help to increase the

*Read at the meeting of the Colorado Hospital Association, Denver, December, 1927.

appropriation that is made for the department.

It is often with a feeling of reassurance that the patient finds himself in a cheerful room filled with interesting things, and away from the hospital atmosphere. Group work is an excellent incentive to the depressed cases. We try to maintain an atmosphere of activity and friendliness. Seventy-five per cent of the patients work under the instruction of two occupational therapists.

Work Is Not Commercialized

In the industrial scheme of the institution, the occupational therapy department is the creative center, but considered from the point of view of the patient it occupies a unique place. We take new patients who do not fit in elsewhere or those who have especial abilities along the lines of work in which the department specializes. We send from the department patients who are able to adjust themselves satisfactorily at some other level. Our advance should not be along commercial lines, but toward widening the scope of our institutional activity. These results may be accomplished in the department through the efforts of the patients.

Occupational therapy is of great value in healing potential mental cases in the following ways:

It arouses and develops attention; it aims to arouse the patient's interest in his personal appearance, in his environment, and to awaken interest in the problems of the outside world; it creates initiative; it substitutes encouragement for discouragement; it restores functions to disabled joints and muscles; it has normalizing influences; it conserves the habit of work and prevents habits of chronic invalidism; it fits a man to take up a job when he leaves the hospital after a period of convalescence or idleness; it raises the morale of the whole hospital; patients become quiet and the discipline of the ward is better managed by the nurse. It is of economic value to the hospital in that it shortens the duration of the patient's stay in the hospital.

How the Patients Work in Large Hospitals

In large hospitals the patients are trained to work in the laundry and sewing department, bakery, mattress shops and gardens. Rugs, baskets, pillows and table covers are woven by the patients for the wards and furniture is repaired and painted, books are bound and chairs caned for the hospital. Waste materials are used as far as possible, such as burlap bags, rags, flour sacks, tea matting, cigar boxes, old blankets, old sheets and many other materials that may be found in the large institutions.

Color and design are the basis of all handicraft, and an intelligent and well trained conception of

both subjects is essential to the occupational therapist.

If an institution is to carry on occupational therapy successfully, six things must be done, says Horatio M. Pollock in the *Maryland Psychiatric Quarterly*: Suitable rooms and adequate equipment must be provided; trained teachers must be employed; a systematic, progressive course of instruction must be outlined and followed; an adequate system of records must be used; a revolving capital fund must be provided; there must be full cooperation between physicians, nurses and teachers of occupational therapy.

The success of occupational therapy is dependent on the ability of the director of occupational therapy, the abilities and personalities of the aids and the close cooperation of the medical staff.

Local Tuberculosis Sanatoriums Needed

Safety and efficiency in fighting tuberculosis require that there be at least one bed in a tuberculosis institution for every death caused by that disease, according to a statement by Dr. Robinson Bosworth, medical director, Rockford Municipal Tuberculosis Sanatorium, Rockford, Ill., in a recent issue of the *Illinois Health News*.

Dr. Bosworth also said that the beds should be distributed throughout a community, so that the sick would not have to go too far from their homes in order to receive treatment. To have the center of treatment far from the source of the disease, is nearly as bad as having no treatment at all. Beds should be available in sufficient numbers and for all social classes.

In order properly to educate the tuberculous person to make use of a sanatorium, it is necessary to have nurses trained in tuberculosis, and to have them in the field at all times visiting those afflicted with the disease and encouraging them to come to the institution for aid.

In a growing city with a population of 100,000, plans should be made for the ultimate construction of an institution with 100 beds, which can be enlarged without undue expense or trouble.

"Locking Out" the Emeritus Professor

An editorial appearing in the *Atlantic Medical Journal* says that "It is most deplorable that an emeritus professor should be denied hospital privileges by the institution he has served faithfully." There are many institutions that retire the personnel of the major faculty at a certain age, and while there is no argument against this procedure if, at that age, a man is no longer dependable or conditions are such that he becomes inefficient, it means that he must seek elsewhere, possibly among strangers, for the hospitalization of his private patients.

It seems that when a man has devoted his life or a great part of it to the service of an institution, he should be granted some privileges that will enable him to continue his practice among friends and in familiar surroundings.

Make the Newspaper Your Ally

"**H**E'S GONE to the hospital," John Bain tells Mrs. Bain when she asks him how Cousin John is. Then Mrs. Bain starts worrying. She just knew right along that there was something the matter with Cousin John, and he let it go so long, too. What will Cousin Emma do now?

And Mr. Bain tells his wife that it's no use to worry and "I guess everybody who goes to a hospital doesn't die."

Such is apt to be the general reaction to hospitalization. Many people still think the hospital is a place where only the most serious cases are taken and most laymen attach great significance to a friend's illness when he "goes to the hospital." Of course, we know that the hospital is the best place for one to be when disease sets in, but homes have been used for hospitals so long that it is not easy to overcome the idea that the hospital is a place for ailments too serious to be treated in the home.

"He's gone to the hospital." Must be a pretty sick man, reasons the popular mind. Medical men state that it would be much better if people would use the hospitals more and the homes less, as hospitals. This can be brought about, and the general interest in health matters and the increased publicity that hospitals are getting through the press and other mediums, are doing much to eliminate the old conception of hospitals as a place for the seriously ill only.

Not so long ago only the most serious cases were taken to the hospital. Minor ailments and the general run of diseases were handled in the home. The welfare of the remainder of the family was ignored, while the attention of all was centered on the ailing member. Broadly speaking, when a person was taken to the hospital it was indicative that there was something seriously threatening his physical welfare.

Hospital Conditions Have Changed

Conditions have changed a great deal, but the same conception of hospitals still exists in the minds of many people, and these people are just the ones who can least afford to make their homes into hospitals. When the layman soberly reflects on hospitals he will see that they are not so much places where death is near at hand as places where bodies are being restored to efficiency and well-being, in the most effective and expeditious man-

ner. Unfortunately, however, the popular mind does not soberly reflect in this way. It is more apt to act on impressions, and the impression of the hospital as a battleground of life and death is still strong.

Newspaper publicity contributes much to the tenacious hold this impression still has on the popular mind. Newspapers every day carry stories about death and diseases in hospitals. Prominent persons become ill and away they go to the hospitals. They die, and the story emanates from the hospital. Accident victims are taken to the hospital and many die there. All this unconscious adverse publicity helps to build up a public conception of the hospital as a place a little nearer death than the home.

Publicity, the Answer

It is obvious, however, that the best way to correct the public's erroneous conception of hospitals is by publicity of the right kind. Practically, this end may be accomplished in two ways. First, each month or so the hospital may prepare statistics to show the nature and number of cases treated. Such figures will be interesting to most people and startling to many. They will show that the hospital is a great force in maintaining public health and will portray it as a guardian of public health and a constructive force, and not simply as a place of last resort in times of serious illness. Many hospitals are following some such plan and it is working out advantageously. The ordinary newspaper is glad to get such a story and can rewrite it into an attractive and helpful news item.

Unfortunately people are more prone to build conceptions from impressions than from facts, and this lessens the potency of the statistical service. As far as publicity goes, statistics are interesting, often startling, but except to a few people they are not genuinely convincing. Repetition adds weight, and if such a story appears month after month, the public mind will be impressed. The frequency of the story is more important than the story content. Hammering on the fact that hospitals serve in a variety of capacities and treat a multitude of different cases, both serious and more or less casual, will achieve the desired end.

If Mr. Bain reads month after month that so many cases of a certain nature were treated at a

certain hospital, there is bound to grow in his mind the conception that the hospital is the place for the treatment of such cases, and he will attach no dire significance to going to the hospital with such a case.

Another aspect of the presentation of hospital news can be developed advantageously in this connection. There are smiles as well as tears in hospitals. There is happiness as well as sadness and there are moments of turbulent joy, as well as those of overwhelming grief and sorrow. These stories are not all "sob" stories, and the main reason they don't get into print is that they are unavailable and those who are closest to them don't see them. There is probably not a hospital in the country today that is not harboring some wonderful story of human interest and joy, and the chances are the story will never see the city editor's desk. The newspaper is busy with what it considers the big things—life and death. It is eager to get the human interest story, but it usually stumbles on to it. The hospital can help. All it needs to do is give the newspaper a "tip."

The other day a nurse from the orthopedic ward of a local hospital was seen carrying a large cake from her automobile to the hospital entrance.

"What lucky fellow is to receive this cake?" she was asked.

"Oh, it's for one of my little boys," she said. "He's eight years old today."

There is a story. Here's the little youngster in the hospital, which is doing its utmost to make him whole and happy. He has a birthday and is not forgotten. It is not an easy story to write and must be done well to be effective, but almost every newspaper, even in the smaller cities, has one or two reporters who could put human interest into such a story and make it effective without being tawdry.

This Story Has News Value

This same little boy some day is going to leave the hospital. Some day the doctors are going to tell him he can walk. It will be a wonderful day for him and the only pitiable feature of it is that the world won't know anything about it. No one will be there to chronicle his joy as he takes the first timorous step. I can't imagine any city editor who wouldn't send his best reporter, post-haste, to get that story if the hospital director would simply say, "A little boy who has never walked is going to take his first step today."

The publicity value of such stories is patent. The newspapers can't or won't dig them up. The hospital must cooperate and it is to its advantage to cooperate, for in so doing it is building up a new conception of hospitals in the public mind.

The above illustration is just one of many. Scores of different cases present excellent material for such stories. Those who are in the hospital see these cases. They are not hardened to the exhibition of human emotion, but they are reticent and don't appreciate the publicity value of such exhibitions. Then, too, some have the idea that to give out such stories is unprofessional and cheapening. This may be true if the newspaper is not capable of handling them appropriately. But properly presented, they constitute good publicity for the hospital.

Stories of this nature, coupled with monthly statistical service and anything else of a constructive nature that the hospital director can find, will aid materially in building up the proper public conception of hospitals.

If the hospital director is the sort of man who can talk intimately with the reporter, the result will be most gratifying to each. The reporter will see a dozen good stories where the hospital director will see one, and if there is friendship and confidence between the two, the stories are certain to be presented in a manner not at all displeasing to the hospital management.

Hospital Held Liable for Negligence

Georgia Baptist Hospital vs. Smith (Ga.), 139 S. E. R., 101:

The Court of Appeals of Georgia, division 1, in affirming a judgment for damages in favor of the plaintiff, a Mrs. Smith, says that, ordinarily, an incorporated hospital, primarily maintained as a charitable institution, is not liable for the negligence of its officers and employees, unless it fails to exercise ordinary care in the selection of competent officers and employees, or fails to exercise ordinary care in retaining such officers and employees.

In the instant case the plaintiff (a pay woman patient), while undergoing a major operation in the defendant hospital, and while lying unconscious and helpless, was severely burned and permanently injured (the sight of one eye being practically destroyed) through the gross negligence of one of the defendant's anesthetists, who, while administering ether to the plaintiff, allowed it to come in contact with the plaintiff's face and eyes, thereby destroying her eyesight as stated, and severely burning her face, and causing her intense pain and suffering for many months.

Under the ruling in the first paragraph and the facts of this case, the defendant hospital was not liable for the negligence of its anesthetist, unless it had failed to exercise ordinary care in her selection. However, this court cannot hold that there was no evidence authorizing the jury to find, first, that the anesthetist was incompetent, or that the defendant did not exercise ordinary care in her selection. However, no demurrer to the petition was interposed, and those issues were raised by the evidence adduced, and were charged by the court. The verdict in favor of the plaintiff was authorized.—*Journal of the American Medical Association.*



Heliotherapy Deck Completes Physiotherapy Department

The recent completion of a roof solarium has added the third unit to the physiotherapy department of St. Luke's Hospital, Denver, Colo. This department was established by the management of the hospital in order to keep pace with the modern trend of hospital efficiency. The two units opened previously were the physiotherapy and the hydrotherapy.

After careful investigation, ultraviolet ray transmission glass was used in the construction of this solarium, which is situated upon the roof of the new wing of the hospital. The construction is of greenhouse type, being twenty by twenty-four feet in size and having approximately five hundred square feet of glass. The clear glass is used in the east, west and south sides. The north side is of solid material, with the exception of a window for ventilation. This same plan is used on the roof, three-quarters of which is wired glass, with the exception of the north elevation which is of solid construction.

The solarium contains 250 feet of radiation. It is furnished with wicker furniture and is attractively decorated. The interior is painted white, trimmed in gray, and the exterior is sand

colored, with the exception of the red roof.

As St. Luke's Hospital is situated on a high point in Denver and because the solarium is on the fifth floor roof, an excellent view is afforded, not only of Denver but of the entire Rocky Mountain Range. The solarium was therefore designed to serve a twofold purpose. In the first place, direct heliotherapy treatments can be given during the entire year without undue exposure of the patients. In the second place it is anticipated that convalescing patients will use the solarium, benefiting by the ultraviolet rays of sunlight and at the same time, in the attractive surroundings of the solarium, enjoying the magnificent view afforded by its location.

A solarium of this type, which has been impossible until recently because ordinary window glass absorbs the vital ultraviolet rays, is now made possible by the use of glass that transmits the majority of these rays. This glass has been endorsed by the council of physical therapy of the American Medical Association.

Charles A. Wordell, superintendent of the hospital, believes that St. Luke's Hospital is one of the pioneers to adopt this type of construction.

STUDIES ON HOSPITAL PROCEDURES

Essentials in Staff Organization*

THE organization of any sort of coordinated effort has as its aim the establishment of definite relationships and responsibilities for each member of the group. This is necessary in order that each may understand not only his definite place in the group, but also his individual responsibility insofar as his activities relate to the accomplishment of the major end in view. It is almost axiomatic that the more clear-cut the understanding on the part of each member of the group, of his duties and obligations, both to himself and to each member of the organization, the more likely will be the efficient accomplishment of the task in hand.

Group effort, to be successful, therefore, must represent the coordinated sum total of the abilities of the individuals comprising the organization. But no collective endeavor that exists upon vague, unwritten or supposedly understood human relationships, can succeed, because of the strong likelihood of the entrance of personalities—of friction—which prevent the smooth coordination of those men and women through whose efforts the work is being carried on.

And there enters here another phase to the problem of coordinating and focusing the abilities, the personalities, the skill of many upon one objective. The links of the chain must all be strong and trustworthy if the load is to be carried safely. Each member of every organization must be well trained to perform efficiently the part of the work that is assigned to him. But not only must each be skilled, every human unit of the group must also possess a personality that is capable of being merged into a frictionless and smooth working whole. No army can be comprised of officers alone. There must be contented and efficient subordinates who are willing to labor upon whatever plane they are placed, in order that a major objective may be accomplished.

These statements which surely obtain in regard to the complicated group effort of manufacturing or military enterprises, are logically just as ap-

plicable to an organization of physicians, such as is represented by the staff of a hospital.

The subject of staff organization is old, yet ever new, because there is not in existence as yet a generally accepted standard set-up—a model staff organization so perfected that hospitals may use it as a type from which to copy. Proper staff organization is vital to the welfare of the individual patient. No matter how complete the physical hospital may be, unless its physicians are efficiently organized, their skill, no matter how advanced, will not be likely to result in the greatest benefit to the institution's patients.

Not only is this subject a vital one to the patient, but it is of the greatest importance to the physician himself, to the nurse, to the intern, to the superintendent, and, indeed, to all concerned in hospital work. There are several essentials that are constantly observed in successful and efficient hospital staff organizations:

1. The set-up must be simple, hence easily understood and remembered.
2. The plan must be fair to each of its members.
3. It must be fearless insofar as casting all personal consideration aside in order to best accomplish the aims of the hospital.
4. It must possess the virtue of definiteness—of placing responsibility certainly and specifically.

An attempt will be made as this sketch progresses, to apply practically these basic organization principles.

Staff Is Responsible to Board

It has been said that the modern tendency of hospital endeavor is to subordinate the doctor, and to place the authority for the proper conduct of the hospital, both from the physical and professional standpoints, in the hands of the board of trustees, and its direct representative—the superintendent. Now it has been repeatedly stated in *THE MODERN HOSPITAL* that the board of trustees is, in the last analysis, solely responsible for the excellence or lack of efficiency of the hospital's work. The members of the board of directors of any manufacturing concern are held responsible for the success or failure of the commercial venture in which they are interested. No hospital can be properly conducted when authority and responsibility are divided.

The superintendent is the enforcement officer of the board—its personal representative. The staff members are skilled and highly specialized workmen in the hospital, and are responsible to the members of the board of trustees for the proper application and exemplification of their

*This is the first of two articles on the subject of "Staff Organization." The concluding sketch will appear in the next number of *THE MODERN HOSPITAL*.

specialized knowledge. Because of this straight line of authority, leading from the board through the superintendent, and sometimes through a medical resident officer, the staff cannot claim that it has the authority to hold itself wholly responsible to the public for its acts, and hence exclude the board of trustees from sharing the praise for the excellence of the scientific work performed in the institution, or from receiving the public's censure for the conspicuous lack of this quality.

Patients' Welfare Comes First

Staff organization, then, must be of such a nature, that the efforts of each physician from the chief of service to the humblest assistant, are effectually focused, every day—every month—every year, upon the bed of the individual patient. When the question enters as to whether staff appointments favorably or unfavorably affect, either the position in the community, or the annual income of some individual physician, and when this consideration is given the preference over others, the staff organization becomes unsound. It is a good practice for members of boards of trustees, superintendents and all other hospital workers daily to measure their decisions and acts in the light of one personally applied question, "Is this the best thing for the individual patient, and hence best for the hospital, which, after all, is but one patient multiplied many times?"

It has been said that no type of staff organization has been generally accepted by all hospitals. Perhaps the most primitive organization is seen in the small hospital in which the staff consists of a number of physicians who are practicing general medicine in a community, and who have been appointed officially or unofficially as visiting physicians to the local institution. Here one is likely to find no particular variance in specialized skill in any of the group. Each practices surgery, obstetrics, laryngology or medicine as the occasion demands.

This type of organization is but slightly altered in the institution which purports to be an open hospital, but which lacks many of the features of the hospital that is usually described by this term. In such an institution, there is often no centralization of staff authority, an exceedingly loose organization existing with no elected or appointed officers, and with no definite by-laws or staff routine. Each physician in the community may be permitted hospital privileges, or, on the other hand, there may be a more or less definitely selected group responsible for the treatment of ward patients, but with the existence of a large courtesy list by which physicians under more or

less definite conditions, are permitted to treat private and semiprivate patients in the institution.

Such an organization, while possessing many disadvantages, can be said, in a measure at least, to bring the hospital into very close touch with the community because every physician therein is permitted to use its facilities. It is also said in support of this arrangement, that there is no discrimination against any local doctor, because each has access to the hospital.

But in such an organization, there can be no central control. There can be no proper checking of failures in technique, no standardization of operative procedures, and, here also, it is difficult to maintain any semblance of definite professional responsibility to the hospital and its board of trustees. It is questionable whether with such an arrangement, the interests of the patient can be as well protected as when an organization of medical effort has been effected under definitely enacted hospital rules and regulations.

There is a second type of hospital staff organization which is so simple, that it would seem that no difficulties could arise in placing the responsibility for the proper treatment of patients. In this type of organization, which is sometimes seen in city, state or federal hospitals, a physician is responsible for both the professional and administrative functioning of the hospital. The performance of surgical procedures, as well as the purchase of supplies, is placed in his hands.

In this type of organization, one is likely to find a paid staff, sometimes inadequate in number, and not infrequently there are no interns or student nurses. One sometimes finds an exceptionally efficient and progressive hospital with this type of organization. But it possesses one inescapable point of weakness—it is efficient or it is wasteful, it is scientifically progressive or it is stationary in the same measure as is the surgeon-superintendent.

Highest Efficiency in Endowed Hospitals

Such a hospital may possess but one motivating power—the urge to heal the sick and advance medical knowledge—or it may be subordinated to political expediency. When such a situation arises, the presence of a political aspect to the hospital administration and the lack of an educational and scientific atmosphere may exist as cause and effect.

Again, one sees this type of organization existing in an institution blessed with a heavy endowment, and with a highly trained and well salaried full-time staff. Here the highest type of scientific efficiency may be found. A community is

indeed fortunate to possess such a hospital. It cannot, therefore, be said that the hospital headed by a chief surgeon and staffed by paid physicians, is always an institution in which there is educational and scientific stagnation.

In the third type of organization there is an elected staff, but no clear-cut specialization of its members. Its physicians may be surgeons only in name, and its surgeons, physicians only because of seniority of service or by personal choice. If it were not so frequent an occurrence, it would seem ludicrous to state that in not a few institutions, the surgeon secures his place and title because of length of service, and should he be removed by retirement or death, the laryngologist or the gynecologist or the physician automatically becomes surgeon.

Staff Organization Depends on Size of Hospital

In such an institution, there are likely to be found no definite ward assignments, and while rules may have been drawn up for the medical conduct of the hospital, these edicts are not likely to be closely observed. The hospital with such an organization finds itself in difficulties that appear, locally, almost insurmountable. There may not be found in the community sufficient work for a physician who is practicing all types of medicine, to confine himself solely to a specialty and to be known as one who is desirous of treating only surgical, gynecological or medical diseases. Physicians doing general practice, are not willing or financially able to confine their efforts to but one type of hospital work. Moreover, it may be truthfully said that they are not sufficiently skilled to perform major surgery or laryngology, according to present day standards.

On the other hand, the aim of every hospital should be to offer to the public a specialized service, at least as far as the major branches of medicine are concerned.

This brings us to the fourth type of staff organization. Here we find that definite divisions, such as surgery, medicine, gynecology, obstetrics, laboratory, and sometimes pediatrics, have been established. In the larger institutions, to this list are added neurology, psychiatry and diseases of the chest. In such an organization, the staff representatives of these specialties profess to be able to perform the duties assigned to them, in a manner marked by unusual skill and competence. They are practicing their specialties as a major effort, and are earning their livelihood thereby.

Each staff may represent a division, or there may be a number of departments comprising each division. In some localities, the term department is given a major importance, a division being one

of its component parts. Each division, as it has been stated, may possess its own staff, and the patients who might be assigned in a more complete organization to a department, are treated in the wards and rooms assigned generally to the division. Reference is here made to the placing of neurologic or tuberculous patients in medical wards, or the treatment of genito-urinary, laryngologic or orthopedic patients in the general surgical wards.

In larger institutions, the divisions are usually departmentalized, the main divisions consisting of surgery, medicine, obstetrics, gynecology, laboratory and neurology, such departments as orthopedics, genito-urinary surgery and laryngology being grouped under the surgical division, and pediatrics, diseases of the chest, cardiology and metabolism being included in the organization of the medical division.

As has been hinted above, the details, and hence, the complexity of the hospital staff organization will depend largely upon the size of the institution and the type of its clientele. Where a sufficient number and variety of patients are at hand, the presence of departmentalized divisions is required, and the staff organization hence becomes more complicated. Where a hospital is a part of a school of medicine or cooperates with such a school, the staff organization is again somewhat altered. Sometimes an arrangement exists whereby the visiting staff of the hospital is comprised of physicians who are at the same time teachers in the medical school. Again, in localities where more than one medical school exists, it may be necessary to set aside hospital wards for each college, for the teaching of students, and to look to the professors of medicine for the care of the patients therein.

Develop Rules for Staff Responsibility

Here enter lines of authority leading to the dean of the medical school. This sometimes complicates the hospital organization to the extent of making difficult both the work of the superintendent of the hospital, and the dean of the school as well. It may be said here, however, that any wavering in lines of authority, and in the routine paths of business procedures, is likely to lead to confusion and inefficiency.

Whichever of the above types of organization exists, rules in regard to staff responsibility and procedure must be carefully worked out. Moreover, while it is not possible to condemn as entirely unfit any of the above types of staff organization, at least two fail to possess a majority of the essentials set down earlier in this article. More detailed comment will be made later in this

sketch in regard to this matter, as well as to lengths of service, methods of maintaining staff discipline and centralization of staff responsibility.

It seems wise, nevertheless, in the most primitive type of staff organization that a chief of staff be selected even though specialization does not exist. It is advisable to have a physician who will act as a liaison officer between his colleagues and the board of trustees. The board must have medical advice, and unless it is possible to secure an opinion that is not merely a collection of diversified thoughts upon a medical matter, the board will often find itself in a difficult and embarrassing situation.

Nomenclature Is Confusing

The nomenclature of staff organization is most confusing. One finds a great variety of terms which are descriptive of the relationships and responsibilities of the physician to the hospital. Those most frequently noted are: emeritus physician, consulting physician, visiting chief, attending physician, associate physician, assistant physician, dispensary chief, assistant dispensary chief, courtesy staff—*ad infinitum* and sometimes almost *ad nauseam*. The responsibility and duties covered by these titles vary almost as greatly as the hospitals using them.

The emeritus physician is usually one who has faithfully served the hospital, but who, because of advanced years, or for some other adequate reason, has desired to retire from active participation in hospital work. The emeritus staff exists usually as a courtesy to distinguished physicians—as a partial recompense for past service—and is of no particular practical value to the hospital.

The consulting physician often fills about the same place. To be sure, he may still be engaged in active work, but he has gained a distinction and a competence which make it unnecessary for him to engage as actively as heretofore in practice. He is therefore placed on the consulting list. He may be called occasionally to see unusual cases, and hence it cannot be said that he does not serve a useful purpose from the patient's standpoint.

The visiting chiefs or attending physicians, and these terms are often used synonymously, are usually physicians in the active practice and teaching of medicine who are of the utmost importance to the proper functioning of the hospital's professional work.

The associate physician outranks the assistant physician and is often but slightly less in prominence and skill than the visiting chief.

The assistant is one step lower in the scale of

prominence, and is of much use to the hospital's patients. There seems to be a tendency in some institutions, however, to appoint assistant physicians who are not professionally capable of fully assuming the duties of either the associate or the visiting chief. This practice is not a wise one unless the associate or the attending physician is always at hand.

The dispensary chief may or may not have house privileges, and his assistant is usually a young physician who is desirous of gaining experience in out-patient work.

As far as the resident staff is concerned, one meets with such terms as intern, resident physician, house physician, chief resident physician and medical director.

The intern is usually a recent graduate in medicine who receives no salary but a moderate honorarium, and who is completing one or two years of hospital service in order that he may qualify to take his state board examination.

Resident physicians are usually placed in charge of hospital divisions or departments. They may or may not receive a salary, and they are frequently placed in professional and administrative charge of one or more interns.

The term house physician is sometimes used synonymously with that of resident physician.

The chief resident physician is usually a graduate in medicine of one or more years' standing, and is administratively and professionally responsible to the superintendent or to the medical director if such an officer exists.

The medical director may or may not live within the institution, and may or may not be salaried. He sometimes performs the duties of the chief resident physician and acts as a medical adviser to the superintendent if he is a lay officer, or to the board of trustees. Usually, the medical director is a member of the visiting staff, and is expected to bring about coordination and cooperation between the staff, and the superintendent and the board of trustees. In this capacity, he may spend but little more time in the institution than would be required of him as a regular visiting physician.

T B Clinics Well Patronized by Young Patients

Statistics show that the percentage of young patients attending the tuberculosis clinics in the state of Pennsylvania, ranging in age from six to sixteen years, is on the increase. This is particularly interesting because it gives the clinic workers an opportunity to instill health-giving habits in these young people at the time in life when they most need this guidance and will derive most benefit from it.

Editorials

Excess Baggage

HOW many of us, as we journey through life, carry with us excess baggage in the shape of prejudices, antagonism and habits—things that are useless, unrealized handicaps in our travels. It is surprising how we thus hamper ourselves physically, intellectually and financially; still more surprising is the fact that we grow so habituated to these impediments that we fail to recognize them as such and would acutely miss them if they were suddenly removed.

We load ourselves with such prejudices against certain races, creeds, and persons; we decide that we are adverse to certain ideas, and thereafter will admit to our minds nothing favorable to them; we acquire useless and even harmful habits, to the point where we consider them as essential to our physical and mental processes; we continue routine long after its usefulness has ceased, thus adding a burden to already crowded lives.

The effects of excess baggage reflect themselves on hospital administration to a marked degree. The hospital superintendent should have such a breadth of vision that he will be able to see around prejudices and antagonisms; his self-analysis should search out the harmful results that are bound to emanate from deleterious habits and useless routine; he should be able to recognize excess baggage and rigorously to cast it aside. If he does not, he cannot administrate really well, because his subordinates, always imitative, will themselves develop excess impedimenta. Those who would successfully follow the road to the useful accomplishment that is real success must travel light.

Treating the Family

THE practice of the art and science of modern medicine is daily becoming more difficult—more complex. Laboratories within laboratories, and specialties within specialties are being evolved to cope with the growing demand for greater acuity of the scientific vision.

The physician of this day and age is apparently becoming convinced that to compete successfully with his professional brethren, he must be capable of performing some type of medical work in an especially skilled manner.

But the specialist in treating the members of the sick man's family is still in the future. In-

deed, this is a task that often requires a greater degree of tact and patience than the handling of the acutely ill patient himself. What is more disrupting to institutional orderliness than the irate unreasonable parent, who is ready to storm the uninviting, closed door of the superintendent's private office, or even his private apartment, in order to learn why Tuesday morning is not as proper a time to visit his child as the regular Wednesday afternoon hour. And yet, such an outburst may be but the manifestation of the overwrought mind of an ignorant yet honest and well meaning man. To fail to make the proper diagnosis in such a case would result in unjust and unwise treatment.

Faultfinding with the methods and practices of the hospital is often born of anxiety—of filial, maternal or paternal love, and not of vicious or deliberately unfair tendencies. And it should not be forgotten that even in this supposedly enlightened age there still lurks in the dark corners of the minds of men and women, something of a fear for the safety of loved ones committed to the care of the hospital. Stark fear works startling changes in the behavior of human beings, and unreasoning and entirely unnatural traits are but the commonest of these manifestations. Under its influence, some attack; others recede. Some display moderation and restraint in act and thought; others—suspicion, nagging and irritability.

The doctor and the nurse must know their therapeutics well, but they must understand the diagnosis and treatment of human beings in mental distress just as thoroughly.

But in the scientific abstraction of the medical mind, the consideration of the entirely natural human fears and superstitions of those other than the patient, may be forgotten. The superintendent should be richly endowed with the homely traits of human understanding and sympathy. There is no finer opportunity for manifesting the hospitality that should be synonymous with the name "hospital," than comforting, encouraging and understanding the patient's family and winning their cooperation for the hospital.

De Motu Cordis

EVEN the most primitive savage has some idea of the movement of the blood. The thought that the vital stream pursues a fixed path undoubtedly occurred to many minds before William Harvey began his immortal experiments; Servetus had a half-truth in his studies of the pulmonary circulation and Vesalius had a fairly clear notion of the capillary tree.

Why was it that the world was obliged to wait until 1628 for definite proof that the blood, actuated by an anatomical pump, is never still and follows a definite cycle of flow? The world has greatly blamed Galen for this long delay, because he described the interventricular foramina as the openings through which arterial and venous blood mixed. This was an error that could easily have been corrected had anyone taken the trouble to determine by experimental study what actually takes place. The profession of medicine, by its blind, unquestioning acceptance of Galen's writings, is responsible for the persistence of the error. Harvey, equipped with a thorough knowledge of existing theories, a sound scepticism and an inquiring mind, submitted the entire question to the test and proved that the circulation of the blood was not a movement of mixed air and water. In so doing, he laid the foundation of modern physiology, but not until he had resisted the onslaughts of a coterie of pedantic professors who regarded any attempt to change existing beliefs as little short of sacrilegious.

Many of the beliefs and practices of hospital medicine might profitably be submitted to searching critical analysis. Not all of the canons of our profession are based on the solid foundation of fact; there are few of them, in fact, that might not be improved; a good many of our most sacred tenets could undergo metamorphosis, to their betterment. Hospital medicine needs a Harvey who will relentlessly vivisection the articles of our faith, correct our mistaken notions of physiology and courageously defend his discoveries against the pedants in our ranks.

A Birthright or a Mess of Pottage?

PRESENT day values are too often measured in terms of real or potential dollars. The finer and yet less tangible spiritual aspect of a new venture, is often obscured by economic considerations which, while important, may be much less vital to its greatest usefulness.

Is there a trend toward materialism in hospital work—toward indelibly stamping the dollar mark on the portals of the houses of healing in this country? Has the struggle for the economic existence of the hospital made callous its soul, hardened its heart and caused it to become forgetful of the fine traditions upon which every healing effort is founded?

It can be truthfully said that no matter how stately its architecture, how unbounded its resources, or skilled its staff, unless the hospital combines with the possession of these properties the practice of acts of charity and compassion,

its works will never reach the ideal. Too much science and efficiency unleavened by the practice of those homely virtues of kindness, of sympathy, of understanding, may lead to such vices as institutional coldness and inhospitality—of machinelike treatment of patients *en masse*.

One fears for the future welfare of the soul of the hospital in which are found flower stands and drug stores conducted for profit, from which patients' relatives are importuned to purchase articles for their own or their friends' use. Is it wise for the hospital by thus entering into competition with the shops near by, to barter, like Esau, its birthright of deserving appeal to the public for generous support, respect and encouragement, for a mess of pottage represented by the petty profits on such commercial ventures?

It should be remembered that charitable institutions must still certify that they are not conducted for profit and that few hospitals realize a return on their operation as a whole. Yet the principles underlying such attempts at money making savor strongly of commercial buying and selling. It is questionable if, from the money standpoint only, the hospital's income is favorably affected by the adoption of a policy of this description.

Sloppy Dick

THERE are some people who seem almost incapable of keeping themselves neat. Such persons are usually also not clean. They wear food splattered, unpressed clothing, rumpled collars, baggy trousers and unpolished shoes decorated by a roll of stocking.

The excuse is sometimes made that such a person is so interested in his technical work that he does not take pains with his personal appearance. In the language of the streets, this is "hokum." Such a condition results either from ignorance, lack of pride or plain laziness. "Sloppy Dick," has no place in the hospital organization, no matter how competent he may be in other respects. A man whose hair is untrimmed, whose finger nails are neglected and who looks as though he had slept in his clothes, has no place in any capacity in a hospital. He is a bad advertisement for the institution.

Hospitals are judged to a considerable extent by the appearance, carriage and demeanor of their employees. Worst of all, a single "Sloppy Dick" will go a long ways toward undermining morale, and such persons, if they cannot or will not "police themselves up" and keep themselves "policed," should be given the opportunity to display their talents in other fields.

Talking It Over

THOSE three monkeys guarding their mouths, their eyes, their ears, should have a prominent place in every hospital. The principles they exemplify should be impressed upon the personnel of our hospitals. They should be enshrined as titulary deities, safeguarding tongues and eyes and ears.

* * *

HOW easy it is to see too much and thus wound others. In our efforts to benefit patients, it is so easy ruthlessly to invade their privacy, to pry into what is none of our business, much as did the voluntary social welfarer who forced the little girl into the admission that her father's occupation was that of bearded lady in the side show. It is just as well that we see not too much. After all, patients, in addition to being vehicles for disease, are human beings. We have enough proper business of our own, without trying to mind that of others.

* * *

EVERY schoolboy remembers the tragic myth of Pandora, and the box which she was forbidden by the gods to open. Overcome by feminine curiosity, Pandora, whose name signified "the gift of the gods," one day cautiously lifted the lid of this casket, and ere she could replace it, out came a great group of plagues—both physical and mental ills, to torment man. But one thing remained in this mystic box, and that was hope.

What a gift of the gods is hope to the sick man—for restful nights, for surcease from pain, for the welfare of loved ones, for ultimate recovery! There is no drug within the physician's reach that so continuously and certainly sustains the heart's beat; so stimulates every vital force to combat disease, as does this intangible thing called "hope." And it is within the power of hospital superintendents, doctors and nurses to keep alive this flame, which is often the determining factor in the patient's fight for return to health.

* * *

WHY is it that as a nation we cannot practice moderation? Is there something about us that sends us flying from one extreme to another and is there no cure for this condition? We abused alcohol until drastic laws were passed, yet these laws do not seem to have greatly stemmed the tide of excesses. We start on an orgy of automobilism, until nearly every man, woman and child drives at breakneck speed down country lanes and city streets. We decide to have huge buildings and immediately offices and homes go skyward at an ever increasing rate, and engineers vie with one another to make their buildings the tallest, the biggest, the most ornate—but seldom the finest.

* * *

FLAPPERISM was such a menace a few years back that it became the talk of the civilized world, and today we are swinging almost as fast back to a subnormalcy of respectability, which will be an equal menace to sound common sense and equanimity. Florida was built, boomed, sold and then forgotten almost overnight. A civic club started a few short years ago and today we simply have to belong to one of thirteen or fourteen such organizations or cease to function as business people.

* * *

THREE years ago everyone was doing cross word puzzles, with an industry deserving of greater accomplish-

ment. Last year "Ask Me Another," was the force behind the disintegration of families; tomorrow something equally asinine will be demanding our attention. In the Mid West you are a social outcast if you don't play bridge four nights a week, while in the East you must be informed on every dramatic production, good, bad and indifferent, or accept the wall flower position. We accumulate great sums of money and then are totally and temperamentally unable to enjoy it. Are we subjects for the psychiatrist? Perhaps, but again it is to be hoped we won't realize this or we will all become amateur psychiatrists and go around examining each other's mentalities.

* * *

IN HOSPITAL work we must never doubt ourselves. If we have not self-confidence, the sick will not trust us. Check our professional judgments we should, but never should we doubt our integrity of purpose.

* * *

CALIFORNIA, beckoning with rosy fingers, calls to us; mountains and valleys, seascape and landscape, forests and deserts await us. Hospitality plus, soul-satisfying pleasure and great widening of the mental horizon will all be ours. Now is the time to make plans and secure reservations. Our San Francisco meeting should be our biggest and best.

* * *

ALMOST any moron can make a living by working eight hours a day, but in the catalogue of success, it is the ninth and subsequent hours that count. The hospital worker who just gets by will soon be given the go-by by those who put extra hours on the job and in study in order to prepare themselves for a better one.

* * *

A LIST of good reading recommended for the hospital personnel would be an excellent thing. Any such list should not be confined to technical subjects alone but to general reading. There are so many fine books published these days that great benefit would result if once a month a list were posted. For instance, "About Ourselves," by H. A. Overstreet; "Other People's Daughters," by Eleanor Rowland Wembridge; "Why We Behave Like Human Beings," by Prof. George Dorsey, and other books of like character are easily read, highly entertaining and would be beneficial to those in hospital work. If, combined with these books, were some on diets, nursing and other strictly hospital subjects, the list would be appreciated by all those who would heed it.

* * *

READING habits are a pretty good index of character, and characters may be formed by the cultivation of good reading. People who confine themselves to the sensational newspapers, the confessional type of true stories, the western and detective thrillers and kindred reading, have stopped growing mentally, whereas the perusal of good current fiction, philosophical discussions, written in good literary style, and magazines of worth, cannot but mold the reader into a more cultural and inspirational person. There should be no black lists of reading as to subject matter, except as it is trivial or trashy. Agreement or disagreement with constructive or thought-provoking magazines should not be a bar to reading, as none but a moron will take everything that is written for gospel. It is enough if the article starts discussion, so that the truth may be ferreted out. Intelligence begets tolerance and of all the virtues tolerance is the most to be desired.



The San Francisco Auditorium.

Underwood & Underwood.

Practical Problems on Programs at San Francisco

FROM every standpoint, but particularly from that of the program, the meeting of the American Hospital Association and its allied associations in San Francisco, August 6-10, will be the most enjoyable and the most worth while that has ever been presented.

Entertainment features that are quite unique, a program that is practical, with but few set speeches and many round tables, a galaxy of speakers who have earned the right to be considered leaders in the hospital field, an especially interesting trustees' section and many other factors are being blended together to create a meeting that will long be remembered.

Varied Program Is Planned

From the time that the special trains leave eastern points, until the last delegate returns home, the occasion will be one of rest, relaxation, delightful entertainment and a thorough discussion of every major problem that the hospital executive is facing today. Great credit is due to the program committee, to the trustees of the American Hospital Association, to the local arrangements committee, and to Dr. Bert W. Caldwell, the executive secretary of the association, for the preliminary work that has been done.

There is every indication from the letters that have been received at the association headquarters and from the sentiments that have been expressed

at state and sectional meetings, that the numbers attending the meeting will be far greater than at previous meetings, and this, together with the large delegation from the western coast, insures complete success for the San Francisco meeting. If there existed any doubt in the minds of some as to the value of making the trip, this is fast being dispelled by a consideration of the program that is being prepared.

The special trips from eastern points to the Coast are in the hands of the American Express Company, and it is believed that much trouble and annoyance will be saved by making arrangements through this bureau. The company has a set price for the trip, with several stops. This price includes all meals and side trips, and it is doubtful if the delegate would be able to do as well on his own initiative. However, there is nothing compulsory regarding these trips and those who feel that either time, money or trouble will be saved by making their own arrangements are urged to do so.

Many of the states are preparing for special cars or trains and it is expected that the eastern section of the country will join with the Midwest group at Chicago, for one big caravan that will convey the assemblage to San Francisco. Many members of the Protestant Hospital Association will join the party at Chicago but will leave it in time to go direct to the meeting hall in Frisco,

arriving in time for the first session.

Number One Special will leave Chicago on July 29 at 11 a.m., and will arrive in San Francisco at 7:30 a.m., Friday, August 3. Stops will be made at Denver, Colorado Springs and Salt Lake City. Number Two Special will leave Chicago, 11 a.m., July 29, and will arrive in San Francisco at 8 a.m., August 6, in time for the American Hospital Association Convention. Stops will be made at Denver, Colorado Springs, Salt Lake City and Los Angeles. The stay in Los Angeles will be from 8:30 p.m., August 2, until 8 p.m., August 5. The first trip, including railroad fare both ways, a lower berth going, meals up to San Francisco, sight-seeing at stop-over points, transfer charges and other necessities will cost \$167, while the second trip will cost \$195.

Attractive Trips Planned

In addition to these straight trips, three tours have been arranged. One includes a visit to the Grand Canyon on the return trip; another includes Yellowstone Park, and a third includes Seattle, Wash., Vancouver, B. C., and the Canadian Rockies. Information may be obtained from any American Express Company's representative in any city or town. It is impossible in this limited space to describe all of the features or the advantages of the trip, and it would therefore be advisable to consult with those in charge.

San Francisco and the whole of California will welcome the hospital people. The local arrangements committee, with Dr. Howard H. Johnson, superintendent, St. Luke's Hospital, San Francisco, chairman, assisted by Dr. R. G. Brodrick, Stanford University Hospitals, San Francisco, Dr. L. B. Rogers, managing director, St. Francis Hospital, San Francisco, Dr. Ray Lyman Wilbur, San Francisco, and the other members of the committee are arranging for the hospital people who attend the 1928 convention, a welcome that will surpass that of any previous year. The hotels are making ample provisions to provide for all the guests, and the San Francisco Chamber of Commerce and the Chinese Merchants' Chamber of Commerce are planning added attractions. Arrangements are being made for a sail down the Bay into the Golden Horn, for automobile rides by way of Leland Stanford University and the University of California to the interesting places through San Jose Valley and the mountains above San Francisco. One evening will be given over to the local entertainment committee and they have planned a night in Chinatown. The Chinese Chamber of Commerce is cooperating to make this night a delightful one and the Chinese theaters, Chinese shops and other places of interest, will

be kept open for the accommodation of the guests. A dinner will be served at the Mandarin Inn, where another entertainment will be featured.

On Monday afternoon the reports of the various standing committees of the association will be presented, and so far as possible disposed of. On Monday evening the formal opening of the convention will be held in Convention Hall. The governor of the state, the Hon. C. C. Young, will deliver the address of welcome on behalf of the State of California, and the Hon. James Rolph will extend a welcome on behalf of the City of San Francisco. These remarks will be incorporated in the presidential address of Dr. Joseph C. Doane. The music to be provided is the best that San Francisco can offer and after the close of the presidential address there will be an informal reception, with the president and the board of trustees of the American Hospital Association, and their wives, and the members of the local arrangements committee, and their wives, in line, after which there will be music and dancing.

The open forums will be conducted on Tuesday, Wednesday and Thursday, and every phase affecting hospital management, maintenance and procedure, construction and equipment, will be discussed. Frank Chapman, director, Mount Sinai Hospital, Cleveland, will be the general director or coordinator of the open forum session on Tuesday morning, and will have as his assistants C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., G. W. Curtis, superintendent, Santa Barbara Cottage Hospital, Santa Barbara, Calif., Helen Anderson, dietitian, Scripps Memorial Hospital, La Jolla, Calif., and Carolyn E. Davis, R.N., superintendent, General Hospital of Everett, Everett, Wash. The general subjects of the open forums on Tuesday morning are as follows: "A Hospital, Like an Army, Travels on Its Stomach"—the dietary; "The Romance of Figures"—accounting, purchasing and issuance; "The Backbone of the Hospital"—the medical staff; "The Nurse—Her Problems, Province and Prerogatives."

A Departmental Council to Be Held

On Tuesday afternoon the administration session will hold its afternoon session and it will take the form of a departmental council. The following subjects will be presented by leading thinkers in their respective lines: "The Mutual Problems of Medical Practice and Administration"—by the attending staff member; "My Contribution to Hospital Service"—by the supervisor of service; "Coordination of Nursing, Education, Administration"—by the superintendent of nurses; "What Have I to Bring to the Care of

the Patient?"—by the social worker; "Interdepartmental Problems of Diet"—by the dietitian.

The construction section, under the chairmanship of Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, will present an interesting program on Tuesday evening.

Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, will conduct the open forums on Wednesday morning, and he will have for his coordinators, Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford Conn., Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, and G. W. Curtis. The questions to be discussed are: "Everyday Hospital Problems;" "Business Methods in Hospitals;" "Hospital Costs and Charges."

Samuel M. Jackson, president of the board of trustees of Tacoma General Hospital, Tacoma, Wash., will preside over the general session on Wednesday afternoon. This program will be one of the most interesting and profitable that has ever been presented in any convention. The chairman will give the opening address, and this will be followed by an address on endowments by a trustee of national reputation who is interested in endowed hospitals. This will be followed by a talk "The Relation of the Hospital to Its Community," by the Right Rev. W. Bertram Stevens, Episcopal Bishop of California, Los Angeles. The Hon. Harrison Robinson, Oakland, Calif., will follow Bishop Stevens on the program, and will address the assembly on "The Coordination of Community Hospital Facilities." The next address will be on "The Relation of the Staff and Board to the Hospital Superintendent," by Sidney G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich. Mr. Davidson will be followed by an eminent physician on the Coast who will speak on "The Relation of Hospital Board Directors to the Medical Staff." Each one of these subjects will be handled by a distinguished speaker, experienced in the particular phase of hospital relations assigned to him for discussion. It will prove an inspiring program from every viewpoint.

Banquet Will Be on Wednesday

The traditional convention banquet will be given on Wednesday evening, either at the St. Francis or the Palace Hotel. This banquet will be addressed either by Dr. Ray Lyman Wilbur or by some speaker of international prominence, after which the annual reception and ball of the association will be held in the hotel ballroom.

On Thursday morning the open forums will be coordinated by Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago. The following

subjects will be discussed: "How Shall We Build Our Hospital?" "The Social Worker and the Hospital;" "How Shall We Finance the Building and Maintenance of Our Hospital?" "The Back of the House: Its Function and Importance."

The last subject includes the power house, laundry, housekeeping, maintenance and repairs. The following are in charge of these round table discussions: Heber Grant, superintendent, Latter



President Doane.

Day Saints' Hospital, Salt Lake City, Utah; Dr. P. W. Wipperman, superintendent, Decatur and Macon County Hospital, Decatur, Ill.; E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.

On Thursday afternoon the general session will be devoted to the subject of special hospital problems, and will be presided over by President Doane. This program will be unusually interesting, both from a practical and an academic standpoint. The important papers to be contributed at the Thursday afternoon session will be "Impetigo in Lying-In Hospitals," by Dr. Harmon P. B. Jordan, superintendent, Providence Lying-In Hospital, Providence, R. I.; "Understanding the Hospital," by Dr. Brodrick; "Returning the Chronic Patient to Economic Usefulness," by Dr. B. W. Black, director, Alameda County Hospitals, Oakland, Calif., and "What the Hospital Is to the

Intern," by Dr. Percy T. Magan, dean of the College of Medical Evangelists, Los Angeles. "Food for Health," will be discussed by Frances Stern, Boston, Mass.

The local arrangements committee has set aside Thursday evening for the night in Chinatown. This will be one of the pleasant relaxations of convention week and the local arrangements committee is preparing to do the honors in the usual approved San Francisco style.

Friday morning will be given over to the final reports of the committees and the transaction of business, and at twelve o'clock the convention will adjourn promptly.

In addition to the general sessions, the different sections are arranging programs that are of unusual interest. The dietetic section, under the chairmanship of Bertha E. Beecher, assistant superintendent, Christ Hospital, Cincinnati, will present its report on "Dietary Service and Equipment;" an address will be given on "The Social Worker and Dietetics;" a paper on "The Hospital Superintendent and the Dietetic Department," will be read by L. G. Reynolds, superintendent, Methodist Hospital of Southern California, Los Angeles, and a paper on "Diet in Relation to Arthritis," by Dr. F. F. Copp, Scripps Memorial Hospital, La Jolla, Calif.

Small Hospital Program Is Interesting

The small hospital section is arranging a session on "Promoting Your Hospital in Your Community," when a paper on "Popularizing Your Hospital Through the Social Service Department" will be presented by Mrs. Chas. W. Webb, director of social service, Lakeside Hospital, Cleveland; another paper on "Effective Hospital Publicity," will be given by Wallace F. Vail, superintendent, Pasadena Hospital, Pasadena, Calif. The following subjects will be discussed: "Effective Types of Hospital Publicity," led by C. J. Cummings; "The Standing of the Hospital in Its Community," by John Mannix, superintendent, Elyria Memorial Hospital, Elyria, Ohio, and "The Community's Attitude Toward the Hospital," by Dr. MacEachern.

The teaching hospital section is arranging a program of special interest to the teaching hospitals, and further details of this program will be given in a later issue. The other sections are arranging their programs in conformance with the unusually high type and character of the general program.

The American Occupational Therapy Association is developing a program that is particularly interesting, and among the subjects it will cover are "Some Recent Surveys Made by the American

Occupational Therapy Association," by Marie E. Shankland and the president's address by T. B. Kidner, New York. Reports of the various committees will also be submitted. The subjects of this program are as follows: "The Program of Occupational Treatment at the National Home for Disabled Volunteer Soldiers, Los Angeles County, California"—Col. James A. Mattison, National Home for Disabled Volunteer Soldiers, Soldiers' Home, Calif.; "Occupational Therapy Treatment for a Group of Spastic Children Under Twelve Years of Age"—Susan Allan Paisley, Los Angeles City School System, Los Angeles, Calif.; "The Organization of a Curative Workshop"—Edith V. Evans, Junior League Curative Workshop, Milwaukee, Wis.; "The Problem of the So-Called Chronic Homebound Patient"—Eloise P. Finley, supervisor of occupational therapy, Association for Crippled and Disabled, Cleveland; "Report of Standing Committee on Research and Efficiency"—chairman, Marian Clark, University Hospital, Ann Arbor, Mich.; "Selling Occupational Therapy"—Mrs. Ethel G. Dana, occupational therapy expert, U. S. Veterans' Bureau, Washington, D. C.; "Occupational Therapy Management of Deteriorated Patients"—P. G. Lasche, M.D., medical officer in charge, U. S. Veterans' Hospital, Palo Alto, Calif.

The Association of Hospital Social Workers is arranging its programs so as to include discussions of all phases of social service work, and the final program is nearing completion. The Children's Hospital Association of America, under the presidency of Robert E. Neff, superintendent, University Hospital, Iowa City, Iowa, has arranged a wonderful program which will be completed in the near future.

T. B. Problems to Be Discussed

The program of the tuberculosis section which will be carried out under the chairmanship of Dr. Glenford L. Bellis, Muirdale Sanatorium, Wauwatosa, Wis., is as follows: "The Evolution of the Sanatorium: Its Future Development"—W. A. Gekler, M.D., Albuquerque Sanatorium, Albuquerque, N. M.; "The Sanatorium as a School in Tuberculosis"—Dr. Henry Sewall, National Jewish Hospital, Denver, Colo.; "Social Service in the Treatment of Tuberculosis"—Marie Lurie, Tuberculosis Service, Chicago; "Nursing of the Tuberculous Sick, a Specialized Service;" "The Therapeutic Effect of Sunlight, Natural and Artificial"—Horace Lo Grasso, M.D., Perrysburg, N. Y.; "Treatment of the Chronic Patient"—Dr. F. M. Pottenger, Monrovia, Calif.

Many special tours are tentatively arranged for the return trip.

The Modern Hospital Reading Course: Lesson XVIII

The Out-Patient Department

By E. H. LEWINSKI-CORWIN, Ph.D.

Director, Hospital Information and Service Bureau, New York

WHEN the radicals in the French Constitutional Assembly of 1848 were attempting to put every possible safeguard into the constitution, and the document was beginning to assume huge proportions, the poet-statesman, Lamartine, who presided over the assembly, remarked: "Gentlemen, let us leave something to Providence."

When I began to block out this chapter of the reading course, I was reminded of this remark. So much has of late years been written on the subject that one suffers from an *embarras de richesses* when attempting to condense the underlying problems and principles of out-patient work within the compass of a brief paper.

In spite of the fact that so much has been written and said about the dispensary, comparatively little has been done to raise its standards of administrative and medical practice. The reasons for this slow progress are the eleemosynary traditions of the dispensary and the rapidity of its growth in the United States since 1910. While in 1910 there were 574 dispensaries, the number increased to 2,300 in 1916 and to 5,726 in 1926.¹

As is true of evolutionary processes in general, with the growth in numbers comes differentiation. The out-patient departments of hospitals gradually added departments corresponding to the medical specialties and the special hospitals established ambulatory clinics. Then with the growth of the public health movement came into existence the tuberculosis, venereal disease, prenatal, infant welfare, mental and dental clinics, also health centers. There has likewise been, particularly during and since the late war, a considerable expansion of organized medical activity in connection with industrial and mercantile establishments. In recent years, the so-called pay or group clinics have come into existence in response to well recognized socio-economic needs.

It has been estimated that about ten million persons seek dispensary service annually in the United States and that about one hundred thousand visits are made to the clinics daily. This creates a demand for mass production and calls for skillful organization and direction. Old elee-

mosynary standards do not suffice, particularly with the growing intricacies of medical technique. Those who come to the dispensaries are sick and are entitled to as much consideration as those admitted to the hospitals. Why are the latter given all that modern medicine has to offer, and the former treated altogether too frequently in a casual way? I shall not attempt to answer the question. There are numerous evidences throughout the country of recognition of the responsibilities of the dispensary to its patients and to the community, and efforts are being made to improve the character of service rendered.

Educational Importance of Dispensary

The importance of the dispensary to medical teaching and practice is likewise being recognized. Several months ago at the Annual Congress on Medical Education, Medical Licensure and Hospitals held in Chicago, Dr. Irving S. Cutter, dean, Northwestern University Medical School, Chicago, stated that 75 per cent of all undergraduate teaching in medicine can and possibly should be done in the out-patient departments. He said, "We have been somewhat inclined, in our demands for hospital clinical material, to relegate to a place of minor importance the wealth of material offered by a well organized out-patient department. We have been a bit prone, perhaps, to forget that we must teach the practice as well as the principles of medicine, and we have forgotten that the out-patient department offers the best possible cross-section of what that practice comprises."¹

To fulfill its functions properly the dispensary should be adequately staffed and equipped. In a dispensary where the spirit of scientific and careful work prevails, and proper supervision and guidance exist, there is no difficulty in securing a full complement of desirable personnel. Every physician worth his salt looks for opportunities for study and research, and these are numerous in a well run dispensary.

Dr. Cutter believes that the physical plant and equipment of the out-patient department should provide:

1. An adequate number of examining rooms,

¹ Margaret Janicula, "The Recent Growth of Clinics in the United States," THE MODERN HOSPITAL, February, 1927.

¹ "The Use of the Out-patient Department in Medical Teaching." The Journal of the American Medical Association, March 24, 1928.

with adjacent dressing rooms, each equipped with the necessary examining furniture and instruments.

2. A small laboratory in each service.
3. A large laboratory of clinical pathology with adequate personnel, this laboratory to care for all types of pathologic work, including serology and the preparation of vaccines.
4. A metabolism laboratory.
5. An electrocardiograph laboratory.
6. Radiologic and physical therapy departments with ample provision for fluoroscopy, cystography and pyelography.
7. Waiting space in each clinic, not one large common waiting room.
8. An accessible library.
9. A photographic and art department.

Dr. Cutter also maintains that all this equipment is essential even though the teaching hospital occupies the same or an adjoining building, unless the hospital laboratories and services are ample and are under full control of the out-patient services.

This is an optimum demand and far from the possibility of full realization in many institutions, particularly, those not allied with medical schools.

Standards Established

When we organized in New York "The Associated Out-Patient Clinics," in 1912, we realized the need of formulating requirements of equipment and administrative procedure for each division of the dispensary and proceeded to do so on a minimum basis. This was the first attempt at formulation of desiderata in out-patient service. I am now inclined to believe that standards of equipment and organization in medical work should be drawn in the optimum, and not the minimum scale. In recent years the revision of the original requirements was made upwards, in accordance with the just demands of conscientious medical practice. These standards have been adopted by the American Hospital Association and have been published in a separate bulletin.

It should be realized that the application of these standards cannot be accomplished without some expenditure of funds. Studies of cost in well run dispensaries, with adequate accounting practice, indicate that an average of eighty cents per visit is not an extravagant figure. It applies to institutions where the medical staff serves without compensation, but includes all the direct and the prorated indirect charges.

The dispensary can be made a valuable adjunct to the public health movement, both in prevention of disease and in the promotion of health education. This idea seems modern, but

it has been well recognized as far back as 1868. In May of that year, the *New York Evening Post* published an account of the dispensaries in New York City, giving a brief history of their development, management and economic value, and concluded in the following manner:

O. P. D. Work Essentially Preventive

"The dispensaries do their greatest service in the prevention of disease. The patients they care for form but a small part of their annual reports; those they assist in escaping a long and lingering sickness are by far the greater part of the whole number treated. The promptness with which aid reaches the sick poor is the crowning glory of the system. Disease is treated in its incipient stages, and death held at bay beyond the threshold of many a crowded tenement, by the immediate attention patients are able to get through this system. . . . The dispensaries are boards of health in miniature, quietly and unostentatiously averting thousands of physical ills that could never be reached in any other way. They were organized to benefit the poor, but like all successful efforts to improve the condition of a single class, it has been found that their blessings fall, in a different form, upon all other classes."

Although the malnutrition as well as baby feeding and prenatal clinics have been developed in connection with the general out-patient departments, the bulk of so-called disease prevention centers have been established independently of medical institutions, the modern trend gravitates toward hospitals. It is becoming customary for the visiting nurses' associations to establish their stations in connection with the hospitals. The only type of disease prevention clinic that has not as yet shown such a tendency is the industrial clinic.

The educational opportunities that each dispensary possesses have not been fully utilized and a great deal can be accomplished in this direction by exhibits, demonstrations and other methods at the disposal of the clinic authorities.

A great deal has been said about the abuse of the dispensary by patients who are able to pay for services of private physicians. Several studies made in this connection, under medical as well as nonmedical auspices, do not seem to indicate that there is a great deal of abuse. It must be remembered that, according to the study of the public health relations committee of the New York Academy of Medicine, about 80 per cent of the patients applying to the dispensaries go in search of the services of specialists or equipment that is not at hand in the offices of the average practitioner of medicine.

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In connection with the same study, an inquiry was made into the budgets of a large number of dispensary patients, selected at random, and it was found that about 2.2 per cent of the patients were palpably taking undue advantage of the dispensaries. A study in 1912 by a special committee of the New York County Medical Society of New York, led to the conclusion that 10 per cent of the patients seem to be "able to pay for medical treatment under ordinary circumstances, but the margin of income over and above fixed expenditures seemed in most cases so slight that in cases of illness demanding continued treatment or the services of a specialist, to pay a physician would mean for them serious deprivation or the incurring of debt, from which afterwards it would be difficult to escape."

A study of 1,000 cases at the Presbyterian Hospital Dispensary, Philadelphia, showed that in 2 per cent of cases the acceptance of free care at the dispensary amounted to abuse. Similar results were obtained in connection with the studies at the Boston Dispensary, Boston, and at the Washington University Dispensary, St. Louis. The Illinois State Insurance Commission reported in May, 1919, that according to their analysis 4½ per cent of the dispensary patients were "recipients of medical charity which their economic status did not justify."

Why Pay Clinics Are Needed

There is, in addition to those who seek dispensary service because of economic status, a considerable group in each community who require competent medical service of a specialized kind, and who are unable to meet the expenses associated with that type of service in private practice. It is for the benefit of this group of patients that the pay clinics are being introduced. The most outstanding example of a successful pay clinic is that connected with the Cornell University Medical School, New York.

It is generally recognized that the out-patient department of a hospital has, other things being equal, the advantage over a detached dispensary in several respects. The out-patient department of a hospital can and usually does make use of the laboratories and x-ray equipment of the hospital; the patients can be referred to the hospital for observation in cases of obscure conditions, and the out-patient department physicians often have the privilege of observing in the wards the cases they refer from the clinic, if they choose to do so; the hospital facilities are often taken advantage of to afford out-patients the opportunity of a rest over night in the case of minor operations, or when such diagnostic tests as lumbar

punctures are resorted to; upon discharge hospital patients are frequently referred to the out-patient departments for continued treatment, and a link affording the possibility of scientific follow-up of disease is thereby established; finally, there is greater distinction for physicians to be associated with a hospital out-patient department than with an independent dispensary.

The above mentioned advantages could be accentuated and several additional ones of importance secured, if a closer correlation between the out-patient medical organization and that of the hospital could be established. The welding of the two organizations into one, facilitates the development of a single medical standard for the institution as a whole, and the existing chasm separating medical ideals and practices in the two sections of the same institution is thereby bridged.

Mutual Benefit Accrues

Such an arrangement redounds to the benefit of everyone concerned. The hospital profits from the more careful selection by the dispensary physicians of patients for admission to the wards. The dispensary physicians are better able to exercise supervision over patients discharged from the hospital, because of a better understanding of hospital treatment given. A rapprochement between the dispensary and the hospital is conducive to the development of a satisfactory basis for training physicians in the hospital and dispensary.

A method of achieving such an arrangement would be by grading the out-patient service. The appointment to the lowest grade in the out-patient department should be made on a probationary basis of three or six months, and after a successful trial the probationer should, on the recommendation of the chief of clinic and with the approval of the board of trustees, be appointed a member of the dispensary staff in the lowest grade. On completion of a period of satisfactory service he should be promoted to a higher grade, and whenever the conditions warrant, he should be made a member of the lowest grade of the visiting staff of the hospital. A rotating service for the junior members of the visiting staff of the hospital, allowing a combined service in the dispensary and in the hospital, is beneficial.

Whenever such an arrangement exists, it affords physicians a stimulus to enter dispensary service; it adds to the experience of physicians, many of whom, on account of the limited facilities of hospitals, do not get the benefit of hospital association except during the one or two years of internship, and it gives to the hospitals a broader opportunity of choice of their visiting staffs.

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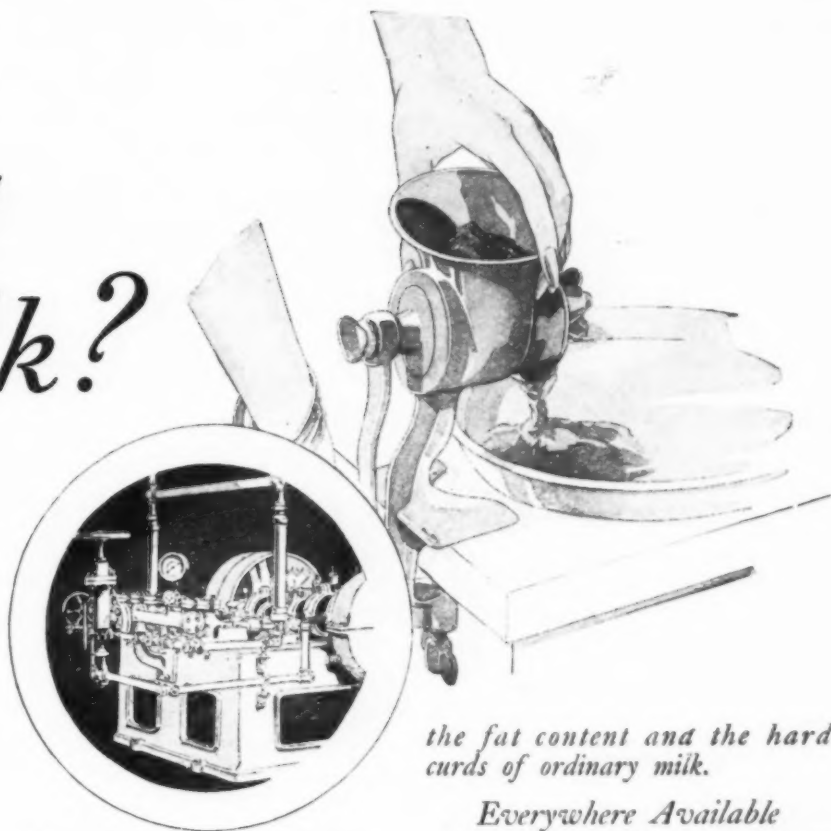
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YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. **THE MODERN HOSPITAL** will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

Who Is Responsible for a "Table" Operating Room Death?

In an institution where two patients recently died during the course of operation, the question arose as to whether the responsibility for this deplorable occurrence rested entirely with the surgeon. The superintendent of the hospital at the regular monthly meeting, flatly put this matter up to the surgical staff and inquired concerning its opinion as to the existence, and if so, the location of blame for these accidents.

Each circumstance connected with these two deaths was carefully examined. In one instance, it was thought that the patient died because of the effect of the anesthetic. The surgeon is entirely responsible for the choice of the anesthetic, and indeed, it is generally accepted that he is also responsible for the technique of the anesthetist during the operation. The surgeon is equally responsible for the performance of a surgical procedure upon a patient who may not be classed as a first grade risk. Unless inefficiency on the part of nurses, improper apparatus or the absence of some other physical aid which the hospital should have furnished him, is proved, there can be but little doubt that in the case of a death on the operating table, if there be any blame attached thereto, the responsibility rests upon the surgeon. Frequently it cannot be said that a death upon the table had any degree of culpability attached to it, as in the case where surgery is employed as a last resort.

In this instance, however, the superintendent was perfectly justified in holding the surgical staff to account for ascertaining the absence or presence of any blame for these regrettable occurrences.

How May the Hospital Dispose of Waste?

No more perplexing problem presents itself to the hospital administrator than the maintenance of a sanitary and orderly condition about the hospital grounds and buildings. The proper removal and the disposition of garbage of all sorts, fall in this class. Added to this difficulty is the disposal of nonburnable materials, such as vegetable and fruit cans from the kitchen. From the postmortem room and the laboratory come materials that must be disposed of and that cannot be left exposed to the public view for any time at all.

In some new hospitals are placed incinerators that are capable of destroying both wet and dry garbage. These installations are not always satisfactory where large amounts of waste are to be burned. In other institu-

tions, connected with the power plant, has been constructed an incinerator with a capacity for consuming, in bulk, any burnable article, whether it be wet or dry. Pathological tissues from the operating room, and occasionally such material from the laboratory, may be consumed if the latter type of incinerator exists.

Usually fruit and vegetable cans are hauled to a near-by municipal or public dump. Sometimes the institution is required to pay a certain sum per load for disposing of this material. The sale of garbage from the kitchen for the feeding of pigs is sometimes possible, and this refuse may bring considerable income to the hospital. The temporary storage of garbage must be performed in an efficient and sanitary manner. There is nothing more offensive in the summer than to see and smell a garbage truck at the rear of the hospital or passing through the grounds, swarming with flies and reeking with foul odors.

It has often been remarked that the test of a good hospital administrator is the appearance of the garbage plant in the rear of the hospital kitchen. To this may be added one further requirement—the efficiency with which he collects and disposes of waste of all sorts.

How Can the Report of Transmissible Diseases Be Made More Efficient?

It is an obligation of the hospital to do everything within its power to forward the cause of preventive medicine. It is impossible to wage a successful campaign against transmissible disease unless health authorities have an accurate idea as to the size of the problem.

Physicians as well as hospitals are sometimes exceedingly lax in reporting infectious and contagious diseases. This step is often looked upon as a bit of red tape for which there is no excuse. On the other hand, hospitals have a distinct responsibility to their public to make sure that information concerning all reportable cases is promptly forwarded to the proper authorities. In large institutions, particularly, this is a difficult task.

Upon the admission of a case of typhoid fever, for example, the diagnosis is usually not certainly made in the receiving ward. It is not commonly possible, therefore, for the report of the patient to originate there. Some days may elapse before sufficient laboratory data have been collected to confirm the diagnosis. Upon the receipt of a positive Widal reaction, for example, the intern sometimes forgets to forward the proper report card. In some institutions, the post card provided by health authorities is placed under the clip of the chart in cases that are suspected of being reportable.

In wards where erysipelas, lobar pneumonia and similar conditions are being treated, less difficulty in securing a prompt report of these conditions is encountered, than in wards where such diseases are treated but sporadically. Sometimes a rubber stamp is used which notifies all concerned that the case has or has not been

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reported. This information is frequently placed across the upper left-hand corner of the temperature chart, red ink being frequently employed. Even this system is fallible. Again, it may be possible to check those cases that have been reported by comparing provisional diagnoses with ward diagnoses, and insisting that office or admitting ward clerks follow these cases through until they are convinced either that the diagnosis is incorrect or that the case has been reported.

No procedure will be carried on faithfully from month to month unless definite responsibility is placed therefor. This is true in regard to the matter under discussion. Hospitals should enter whole-heartedly into any program that has as its aim the prevention of disease, and whether the disease be lues, typhoid fever, scabies, pneumonia or any other condition, the hospital has a definite responsibility to inform those who concern themselves with the protection of public health, that such patients have been received for treatment.

Should the Hospital Maintain a Ward for the Free Treatment of Sick Interns and Graduate Nurses?

There seems to be much interest throughout the hospital field in the question of the institution's obligation for the treatment of the members of its personnel when they become ill. In some institutions, associations of graduate nurses and interns have furnished rooms or wards for the treatment of their members. When this is done, the hospital usually supplies the room and the usual nursing and medical care.

It is necessary, however, for definite regulations to be laid down concerning this matter. If but a few beds exist, the question of the length of time that they may be occupied by any given individual is pertinent. In one institution it has been recently decided that a thirty-day period of occupancy by any one patient is considered fair, and that should there be no waiting list, it is then within the province of the medical director to increase this period of occupancy by ten days. On the other hand, should there be others who desire and require the use of these beds at the conclusion of the above period, the hospital may offer its ward or room facilities at the current rate for the care of these patients.

It was also decided that nursing service other than the usual floor nursing should be supplied at the expense of the physician or nurse requiring the same. The members of the staff in this hospital are to furnish the medical care. The nurse or physician is not permitted to summon to the hospital, physicians who are not upon the institution's visiting roll.

Careful stipulation was also made regarding the type of disease to be treated. It was not felt, for example, that the hospital owed to the members of these associations an obligation for the treatment of contagious or maternity cases. In general, it was decided that the type of disease should be accepted that would normally come to general beds throughout the same institution, and that maternity cases should be treated in the hospital's obstetrical department.

Some hospitals require that such associations as those to which reference has been made, endow beds for the treatment of their members. Sums of from five to ten thousand dollars, are usually required for such an endowment. However, it can easily be seen that such sums are entirely inadequate to meet this need for any great length of time.

It is a fine thing, indeed, from the standpoint of maintaining a high degree of loyalty on the part of interns

and graduate nurses, for the hospital to be able to offer this service. On the other hand, it does not appear to be a service that is demanded of the hospital, but one which is given gratuitously in consideration of the fact that these persons have in the past been connected with the institution. The time for the adoption of definite rules is before the need for the rule arises.

Is a Strict Rule Against the Use of Intoxicants by Interns a Just One?

Some hospital administrators require that members of the intern staff sign an agreement upon beginning their services that, within the institution, they will not indulge in the use of intoxicants, be present when such is being done or bring in alcoholics of any sort. In other words, it is felt that no rule can be too strict in regard to bringing about the highest morale among the members of the resident staff.

The superintendent owes no greater obligation to his hospital's patients, than to furnish them with the ultimate in medical care. The consumption of alcohol by members of the resident staff is sure to mar the efficiency of young physicians, and to injure the moral standing of the whole hospital. To be sure, the resident physician is no longer a child, and he is more or less responsible for his own acts when without the hospital.

On the other hand, any behavior on his part that reflects unfavorably on him as a physician, and upon his hospital, quickly becomes a matter of concern to the institution in which he is laboring.

The hospital superintendent certainly has a right to control the actions of every member of his institution's personnel when such behavior is likely to injure, even remotely, the chances of the sick man or woman. The day is long past when a young physician may be truly successful and at the same time consume alcoholics during his working hours. Since the physician is constantly on call in the hospital, this practically implies that he be strictly abstemious during his intern course.

What Is the Extent of the Hospital's Obligation to Medical Students?

Superintendents of teaching hospitals have frequently endeavored to answer this question for themselves. In some medical colleges and hospitals, it is feared that the demands of education have somewhat encroached upon the principle that the welfare and comfort of the patient must supersede everything else. It is difficult to prevent ward classes from being held at mealtimes. When this is done, the patient's meal is likely to be served to him in an unappetizing condition. Moreover, the delay of an hour in securing his meal, is far from comfortable. Teaching hours should be so arranged that patients may be free to eat their meals at the time scheduled. Critically ill patients should not be used for instructional purposes, nor should those who seriously object to this procedure.

In the hospital, unless it be an integral part of the medical college, there must be certain limitations as to the physical aid to be furnished for the teaching of students. Reference is here made to the necessity of providing blood pressure instruments, blood counting apparatus, trays for minor ward surgery and other materials that are certainly not inexpensive. If the hospital funds are derived from the same source as those supporting the medical school, this problem is not so troublesome. It is certain, however, that patients in teaching hospitals often

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At the corner-stone laying ceremonies, attended by the late Msgr. P. E. Roy, archbishop of Quebec; the Hon. L. A. Taschereau, prime minister of Quebec province; and many members of parliament, it was pointed out that the province is subsidizing all hospitals to an amount equal to \$2 yearly for each inhabitant.

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receive a more thorough study than those in noneducational institutions. While the size of classes permitted to enter hospital wards, the type of patient upon whom teaching is done and the nature of this instruction, are all matters that must be determined from the local standpoint, this basic rule still obtains in hospitals of all sorts—the patient comes first. Nor is it necessary in the application of this rule, seriously to curtail the efficiency of teaching. There need be no diminution in either effort in order to have both successful and efficient.

The practical difficulties encountered by the superintendent of a teaching hospital are unique for that sort of an institution, and often it is not possible to prevent loss or theft of hospital property which is used by large numbers of students. It is the firm belief of THE MODERN HOSPITAL that teaching need not and must not react to the physical or mental detriment of the patient from whom instruction is being given.

How Can a Superintendent Prevent Favoritism Being Shown to Specialty Departments?

This question was asked by a hospital superintendent in whose institution a department of metabolism had recently been installed, and which was felt, by some, to deserve an unusual proportion of the money and supplies available for the hospital generally. As a result, other departments were sacrificed for the benefit of this one. The physician in charge of this department, being active and influential, was able to direct the attention of the members of the board towards his work, while other departments, having unaggressive staffs, suffered as a result.

It is the superintendent's duty to exert a stabilizing influence when matters of this sort arise. It is his duty to see that the patients in each hospital department receive a fair apportionment of the hospital's effort. He is interested in the hospital as a whole, and cannot allow one department to advance at the expense of another, even though such progress may be necessary and laudable. It is therefore his duty to equalize the expenditure of hospital monies, and to see to it that each department is given its share of equipment and personnel. He would indeed be derelict in his duty were he to allow friendship or pressure from members of the board to bring about unjust and unequal distribution of such resources.

On the other hand, it is his duty to encourage the physician who is active and interested in his work, and who is giving much time to the treatment of his patients, just as it is expected of him to chastise those who are not rendering efficient service to the hospital.

It is regrettable that such situations so often arise in hospital work. Nevertheless, it would not be fair to divert to other purposes gifts that have resulted from a staff physician's activity and interest in his own work. It is, however, the superintendent's duty to encourage the development of other departments, so that the hospital may move forward as a whole.

What Is the Relation of the Staff to the Dietary Department?

It is a fact not to be disputed that in many hospitals, the average staff member is woefully ignorant of the details of the hospital dietary. To be sure, he is usually aware that he may order liquid, soft, select or house diet, but as to the scope of the articles covered by this nomenclature, he is frequently totally uninformed. The prescribing of foods is often left to the intern, and while

comparisons are odious, it may be truthfully said the intern is rarely better informed concerning the dietary facilities available in the hospital than is his chief. This may be because medical colleges in years gone by have not stressed the importance of the dietary treatment of disease, or because the busy practitioner has not found time to inform himself concerning such matters.

The relation of the visiting physician to the pharmacist and the drug store is known to all. The dietary department should fall in the same class. In each are to be found therapeutic agents that are delivered only upon prescription of the physician. To be sure, the selection and preparation of foods are often not given the same importance as is the compounding of drugs for the treatment of hospital patients. While in the dietary department there may exist ample facilities for the careful preparation of all types of diet useful in the treatment of disease, yet such a carefully laid out department cannot be of greatest use to the sick, unless the visiting physician is interested in and informed concerning these provisions.

The physician should feel free to call the dietitian in consultation whenever he finds himself confronted with problems that her special knowledge can aid in solving. The dietitian should be interested in the scientific study of patients for whom she is preparing diets. The visiting physician should not discourage this interest. He should feel free to visit the dietary department, and thus learn at first hand, how this department may help him in his work in the hospital. Such visits will do much to raise the morale of the dietary department and to increase the efficiency and interest of the dietitian.

Should the dietary department be unable to fill the requisitions of the visiting chief the superintendent should, of course, be notified of this fact. Strict adherence to administrative procedures should not, however, require the routine approval by the superintendent of dietary prescriptions that have been originated by the chief.

The dietary departments of our hospitals will not render the ultimate in service until they have been elevated to the place of a specialty laboratory, willing and able to fill prescriptions with the same accuracy as is expected of the well regulated pharmacy, clinical laboratory or physiotherapy department.

Is Punishment of Child Patients in the Hospital Permissible?

Most hospitals have strict rules to the effect that nurses or others may not punish children in the slightest degree. This is rather a difficult rule to enforce, and while basically it is sound, it cannot be said that at all times children who are hospital patients would not profit by mild chastisement.

But any permission for such action on the part of nurses would be likely to be misunderstood and perhaps abused, so that even shaking or lightly spanking refractory children is no doubt wisely prohibited. Sometimes it is necessary for the superintendent of nurses to act in the place of the parent, but fortunately youngsters are often so awed by hospital uniforms and the unusual atmosphere of the institution, that they require little discipline.

It is felt that there are many ways of controlling children who are inclined to be refractory, other than by corporal punishment. It is a rare case indeed when the child cannot be reached by such methods. In extreme cases, the cooperation of the parent or of some other member of the child's family, will usually bring about the desired result.



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NEWS OF THE MONTH

Catholic Sisters in Indiana Open Two Large Hospitals

The Right Rev. John F. Noll, bishop of Fort Wayne diocese, officiated at the dedication of the new wing of St. Mary's Mercy Hospital, Gary, Ind., recently. On the same day he officiated at the opening of the new \$1,250,000 St. Catherine's Hospital, East Chicago, Ind. Both of these institutions are operated by Catholic Sisters of the Order of the Poor Handmaids of Jesus Christ.

With the opening of the new wing, the facilities for handling patients in St. Mary's Hospital have been doubled, the capacity now being 265 beds. The x-ray laboratories are in the new building and occupy half of the first floor. The patients' rooms are on the second, third, fourth and part of the fifth floors. The private rooms are finished in a soft shade of green, each having a private bath. Each floor has a separate solarium for use of convalescent patients.

The new surgery on the fifth floor is outstanding in its equipment. There are four major operating rooms, an orthopedic room and an anesthetic room. Modern operating lights, dressing rooms, showers and equipment have been provided.

Government Plans Veterans' Mental Hospitals

The Veterans' Bureau hospitalization bill, authorizing the expenditure of \$15,000,000 to care for the increasing load of mentally ill World War veterans, has recently been passed by the house of representatives. There has always been a shortage of beds for neuropsychiatric patients, although nearly half of the 27,143 sick war veterans are suffering from mental diseases. The committee on World War veterans' legislation accepted the views of specialists in neuropsychiatry, that it is important for mental cases to receive hospital treatment. The fact that the number of mental cases among World War veterans is increasing also gave strength to the argument in favor of a hospital building program.

St. Louis Needs Facilities for Care of Tuberculous

The St. Louis Medical Society, St. Louis, has joined forces with the Trudeau Club, composed of specialists in tuberculosis, to urge a bond issue of \$2,400,000 to meet an acute shortage of hospital beds for patients suffering from tuberculosis. Dr. Howard H. Bell, tuberculosis controller, St. Louis, who is leading the movement, reports that the waiting list for entrance to the Koch Hospital, the only public tuberculosis sanatorium in the city, has ranged between 100 and 150 for a long time, and that in the month of April one patient was admitted.

The Board of Aldermen of the city have proposed that temporary buildings be erected, but this movement is being opposed by medical authorities. The bond issue would provide for a \$1,750,000 addition to the Koch Hospital, a \$350,000 addition to City Hospital No. 1 and a \$350,000 addition to City Hospital No. 2, which is for Negroes. The plans for these additions were drawn several years ago, and are merely awaiting the accumulation of funds for their execution.

Hospital License Law Modified in New Jersey

Private hospitals and nursing homes throughout the country are operating largely without inspection or supervision by public authorities. The temptations of such freedom of operation in many cases have resulted in the charging of excessively high rates for services which may or may not have been beneficial to the patient.

New Jersey has taken a step toward correcting this situation. Although there has been a law providing for the inspection and licensing of nursing homes, no adequate powers were given to the state department of institutions and agencies to control unethical or inadequately equipped and administered institutions of this sort.

At a recent meeting of the legislature the original act was amended to include, "the licensing of private nursing homes and private hospitals for the care, treatment and nursing of persons ill with disease, or who are crippled, infirm or in any way afflicted. There are exempt from the provision of this act, "any hospital, home or institution conducted by or for the members of any religious body or denomination, or legally occasioned fraternal, charitable association."

Thus any nurses' home or hospital operated for profit comes under the operation of this act, and the penalty of operating without a license is \$500 or imprisonment for six months or both.

"Poor" Patients Crowd Dispensaries —Investigation Started

The Academy of Medicine, Cleveland, having received a number of complaints that many patients who are receiving free dispensary services are well able to pay private practitioners, has sponsored a movement to investigate thoroughly the financial condition of the patients and the relation of dispensary practice to the practice of medicine. As a step in this investigation, a commission has been appointed and the members of the commission are distributing questionnaires to the major hospitals and dispensaries of Cleveland. It is believed that the information provided in the replies to the questionnaires will offer a possible solution for the problem.

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News of the Month

The Supply and Demand in Nursing Discussed at Luncheon Meeting

More than two hundred supporters and friends of the Central Council for Nursing Education, Chicago, attended a luncheon on May 3, at which time Dr. May Ayres Burgess, New York, who conducted the study on the grading of nurses' schools, delivered an interesting talk on the findings of the committee up to date.

Doctor Burgess pointed out that there was every indication of the fact that instead of there being too few nurses there are, in reality, too many nurses at the present time, particularly in the private duty field. By an interesting system of charts and figures she showed the ratio of nurses to the graduates of medicine, and brought the estimates through until 1965, at which time the number of graduate nurses would amount to more than four to one as compared to the medical profession. These figures have been based upon comprehensive medical and nursing studies.

She emphasized the importance of eliminating the incompetent private duty nurses and pointed out that supervision was necessary in a great many cases.

Mrs. David Graham presided at the luncheon and turned over the meeting to Mrs. Frederick W. Upham who introduced Doctor Burgess.

Many hospital superintendents attended the luncheon, as well as principals of schools of nursing.

Three Hospitals Added to United Hospital Fund

The hospitals comprised in the United Hospital Fund of New York now number fifty-nine, the following three having been recently added: Brooklyn Eye and Ear Hospital, Brooklyn; the Bronx Hospital, New York, and the Beth Moses Hospital, Brooklyn.

American Nurses' Memorial Stands Uncompleted in Bordeaux

The American nurses' memorial building of the Florence Nightingale School of Nursing, Bordeaux, France, stands as an incomplete memorial to the 291 American nurses who made the supreme sacrifice during the World War.

The school authorities, at the time the project was launched, estimated that a building sufficiently large to house an adequate staff of graduates and pupils for the new hospital could be erected for \$50,000. When this amount was contributed, the lists were closed. About \$51,000 was finally given to the trustees, and construction started early in 1921. The plans called for a central building and two wings. Unfortunately, the increased cost of material and labor following the World War made it impossible to carry out the original plan for this sum of money, and only one wing and the center were completed.

At present there are accommodations for but thirty-six

nurses, exclusive of recreational, class and domestic departments. The unfinished wing would provide housing for an additional twenty-five students and graduates. It is estimated that \$25,000 is the amount needed to erect the other wing.

An effort will be made at the biennial convention of the Nursing Associations, to be held in Louisville, Ky., June 4 to 9, to obtain pledges for the necessary amount. According to an estimate given by the associations, there are 75,000 nurses in America, and if each one gives only fifty cents toward the completion of the memorial, the total donation will amount to \$37,500.

Barnes Hospital Surgical Capacity Doubled

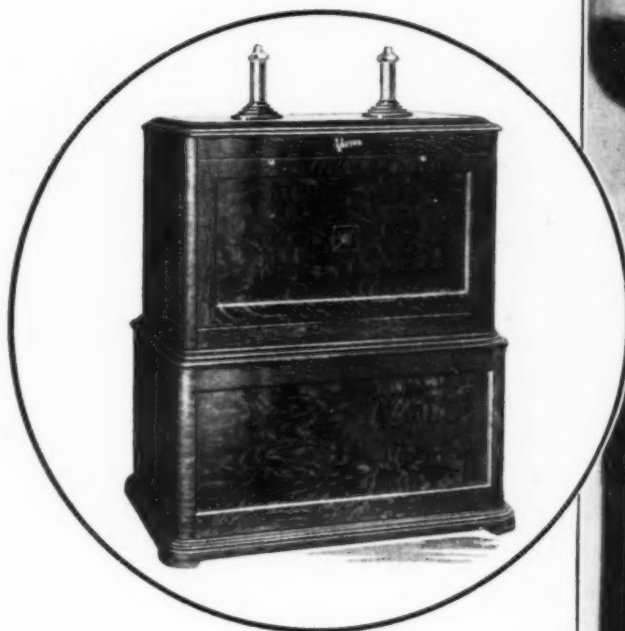
The surgical capacity of Barnes Hospital, St. Louis, is to be doubled by a \$750,000 gift to the Washington University School of Medicine, according to the *Journal of the Missouri State Medical Association*. This will give the hospital teaching facilities in its surgical service superior to any other medical school in this country and comparable only to some of the great institutions of Europe.

The gift was from Frank C. Rand and Jackson Johnson, St. Louis, respectively president and chairman of the board of the International Shoe Company, and the General Education Board, which dispenses the Rockefeller benefactions to education. The General Education Board gave \$450,000 for the medical school activities, the shoe manufacturers giving \$150,000 each to provide the quarters, a three-story addition to the present three-story pavilion of Barnes Hospital, which is affiliated with the school of medicine.

Statistics in the annual report of the Barnes Hospital show that during the ten years, from 1917 to 1927, the average hospitalization period of patients has decreased 5.1 days. The cause for the decrease, it is believed, is the increase in medical knowledge, more skillful diagnoses, and the diminishing resistance of the patients toward hospitalization, which gives the hospital a chance to fight disease before it gains too much headway.

California Announces State Hospital Building Program

Eight California hospitals will benefit by a \$1,000,000 building program which has just been announced by the state. They are: Napa Hospital, Napa, which is to have a new employees' building and physicians' quarters; a new barracks building for the Veterans' Hospital at Yountville; a tuberculosis ward at Southern California State Hospital, Patton; a hospital building at Sonoma State Home, Sonoma; two physicians' homes at Stockton State Hospital, Stockton; two physicians' residences at Agnew's State Hospital, Agnew; assembly hall, chapel and warehouse at Norwalk State Hospital, Norwalk; and a hospital building at the Whittier State School, Whittier.



Remote Control Booth for "Snook" at Cook County Hospital, Chicago, Ill., where two of these outfits have been recently installed.



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A short time ago a questionnaire was sent out covering 150 Victor-Snook machines that were installed ten years ago.

Up to this writing returns have been received on 132, and it has been extremely interesting to learn not only that all of these are in actual use today, but of the general satisfaction expressed by their users. The outstanding fact brought out through these questionnaires is that the Victor-Snook of ten years ago is equal to the demands of the X-ray art of the present, even with the advanced technics that have been evolved in this decade.

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ORGANIZATION

Among the Associations

Dr. Wilkes Reëlected President of Midwest Association

ROUND table discussions, several interesting papers, an exhibit of larger proportions than usual, and several social functions, blended together to make the second annual meeting of the Midwest Hospital Association, held at Kansas City, Mo., April 27 and 28, a huge success. There were in attendance approximately 175 hospital executives from the states of Missouri, Kansas and Oklahoma, while visitors were present from Nebraska, Iowa, Colorado, Texas and Illinois.

Dr. B. A. Wilkes, president of the association, called the meeting to order on Friday morning. Invocation was



Dr. B. A. Wilkes was reëlected president of the association.

pronounced by Dr. A. W. Lindquist, Kansas City. Mayor Albert I. Beach delivered an address of welcome, which was responded to by Dr. Wilkes.

The next order of business was the reports of committees, at which time the treasurer reported a fund of \$602.03 in the treasury. Dr. Rush E. Castelaw, superintendent, Wesley Hospital, Kansas City, Mo., announced the details of the two-day program. Dr. Frank C. English, secretary of the Protestant Hospital Association spoke briefly of the work of that association and the morning session ended with a complimentary luncheon given by the association to those in attendance.

An interesting address was given in the afternoon by Ray Lloyd, Sheldon School, Chicago, on "Factors That

Determine Our Efficiency." This was followed by an address by Dr. Bert W. Caldwell, executive secretary, American Hospital Association, Chicago. Marjorie Vorhees, librarian, Morningside Hospital, Tulsa, Okla., spoke on "Reports and Records." Father C. B. Moulinier, president of the Catholic Hospital Association, Milwaukee, delivered a splendid address on "Beauty in the Hospital," and E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, read a paper on "Supply Control in Hospitals."

Following the papers and the discussions of them, a symposium on "Small Hospital Problems" was conducted by Dr. L. E. Emmanuel, Chickasha Hospital, Chickasha, Okla. The evening session was conducted by Dr. M. T. MacEachern, associate director, American College of Surgeons, Chicago, and a great variety of hospital problems were discussed. Fire risks, costs and charges, anesthesia, collections and other topics were considered at this session, which lasted until after ten o'clock.

Saturday's Sessions

The Saturday morning session was presided over by Dr. A. R. Hatcher, superintendent, Hatcher Hospital, Wellington, Kans. The first paper was presented by G. W. Hanner, superintendent, Methodist Memorial Hospital, Colorado Springs, Colo. He told what was being done for tuberculous patients at his institution. The Rev. H. F. Vermillion, superintendent, Southern Baptist Sanatorium, El Paso, Tex., discussed Mr. Hanner's paper, and the combination of the paper and the discussion proved to be the interesting feature of the meeting.

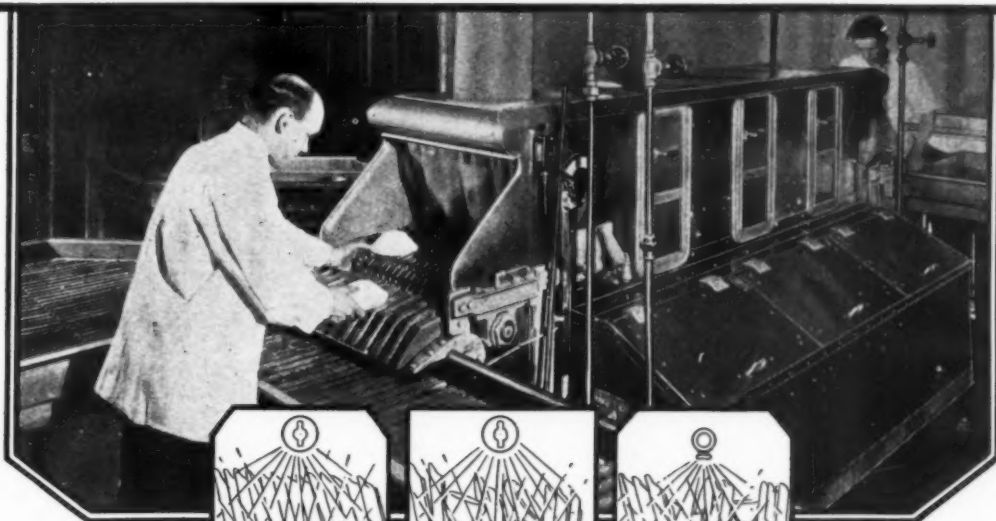
The second part of the session was devoted to hospital publicity, and a paper was read by John A. McNamara, executive editor, *THE MODERN HOSPITAL*, Chicago. This was discussed by Matthew O. Foley, managing editor, *Hospital Management*, Chicago. Sectional meetings were then held by the various states. The noon luncheon was presided over by Marjorie Vorhees, and considerable interest was aroused in the formation of a hospital librarians' association.

Most of the final session was given over to a discussion of the workmen's compensation act, led by F. W. Whitten, Kansas City. Several of the exhibitors were asked to speak and did so. The election of officers resulted in the reëlection of Dr. Wilkes as president. Dr. Fred C. Clinton, Tulsa, Okla., was elected first vice-president, Dr. J. C. Bunton, Augusta, Kans., second vice-president, and Walter J. Grolton, superintendent, Missouri Pacific Hospital, St. Louis, secretary.

In the evening a banquet was held at the Hotel Baltimore at which dancing was enjoyed.

The Midwest Association meetings attracted visitors from many cities and Dr. Wilkes announced on Saturday evening that the attendance had far exceeded the association's expectations. The meeting next year will also be at Kansas City.

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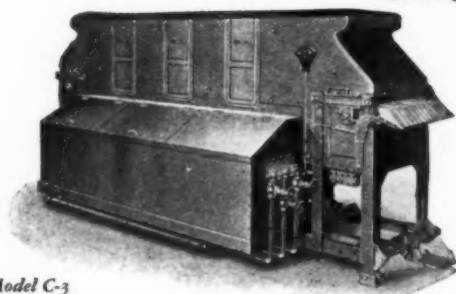
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Among the Associations

Social Workers Hold Annual Conference in Memphis

THE tenth annual conference of the American Association of Hospital Workers was held in Memphis, Tenn., April 30 to May 9, at the time of the National Conference of Social Work. Meetings of the association were held three days in advance of the opening session of the conference. About one hundred twenty-five members of the association registered, most of whom came from Pennsylvania and New York. There were two Canadian representatives and one from Colorado.

In her presidential address, Mrs. Charles W. Webb, director of social service, Lakeside Hospital, Cleveland, spoke of the future work of the association. The major concern of the association in the near future, should be, she said, to study the nature of social service, to link the work done in the hospital with the outside community agencies, and to develop a professional viewpoint. To do this, the association must have coordination, study and leadership. These important elements, she said, could be nurtured by the fourteen standing committees. In concluding her address, Mrs. Webb made a stirring appeal for leadership within the association, not on the part of a few, but on the part of all.

Secretaries' Reports

Of great interest were the reports of the two secretaries. Helen Beckley, the executive secretary of the association, gave a summary of the work of the national office in Chicago during the year. Kate McMahon, the educational secretary, gave a brief history of the establishment of the educational committee, which resulted in the appointment of an educational secretary in 1925. This step was prompted by the shortage of prepared workers, the need for whom was recognized by some boards of trustees, hospital administrators and physicians, who saw the assistance which properly trained workers could give. The educational secretary has been advised and assisted by the educational committee of the association. This committee has met yearly in group conference and is now confronted with four problems concerning training: (1) determining a medical information course that will be basic for all students as well as supplementary courses for students in hospital social work; (2) formulating and arranging the sequence of courses best adapted to produce well trained students in a reasonable length of time; (3) accepting a tutorial relationship to these students specializing in hospital social work; (4) meeting the tests of good teaching, kindling the thought process, formulating definitions and principles, translating the accumulated information and acquiring skill in a productive and professional life.

The subject discussed at the general session meeting was the interrelation of medical and social treatment of disease. Dr. Newton S. Stern, Memphis General Hospital, Memphis, spoke from the viewpoint of "The Relationship of the Social Worker to the Private Practice of Medicine."

He said in part: "The veneration and love of the family doctor is due not only to the cure of the patient, but to the doctor's interest in the family. As our modern hospitals are organized, the relationship of doctor to patient becomes less intimate, so social service has come into being and has taught the doctor the need of understanding the social background. Social service should go a step further and should supply this need in the relationship of the private physician and the pay patient. This new step will have to be a gradual one, for the patient's psychology is different in free and private groups, the private patient resenting the intrusion of a third person."

Gordon Hamilton, New York School of Social Work, presented another phase of this question—"The Medical Social Worker's Responsibility to Other Community Agencies." There are now two factors in social work—the converging of agencies to produce greater efficiency and the fact that social work is becoming more truly social and a professional entity, with social case work as a basis for all types. The approach to the problem is a little different in each group, but there are common objectives for all social work. In 1920, a worker was trained in the art of investigation and since then various ideas have been emphasized, but her function today is diagnosis and interpretation. All agencies are collecting and studying facts to find the relation of cause and effect—social philosophy—but the same facts have a different meaning to each participant, so they should be considered as a whole, with several meanings. The medical social worker should give the report of the medical diagnosis and should interpret it to the outside agencies, explaining the length of time it takes to make that diagnosis.

In a paper read by Antoinette Cannon, Dr. Hugh Auchincloss discussed a third aspect of this subject, "Social Service as a Natural Part of Medicine." Natural and normal should be differentiated, with the emphasis on "natural" as the way of nature. A struggle for nobility throughout the ages is a natural law that governs consciousness. Medicine and social service are children of altruism and the relation between the two will come naturally. Two principles should be noted: First, that medicine and social work are part of the same body, parallel in organization and technique, though differentiated and performing different functions; second, that they are dependent on one another.

Eight round tables were held on the following subjects: The responsibility of the social service department for the admission work; volunteers; reporting of the social data on medical records; the responsibility of the medical social worker to the nonresident patients; case load; the hospital social worker as a teacher of the student nurse; terminology and the social worker in the United States Veterans' Bureau. It is of interest to note that the majority of those attending the round table on social data on medical records, were putting some sort of social data



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Among the Associations

on the medical records. In some hospitals the entire social service record, including correspondence, was an integral part of the medical record. In others, only a slight social service summary up to the point of a social plan was written on the medical record.

As a result of the annual business meeting, Gertrude L. Farmer, executive director, department of social work, Boston City Hospital, Boston, was elected president; Edith Baker, first vice-president; Susie Lyons, second vice-president; Elizabeth McConnell, third vice-president; Elizabeth Gardiner, secretary, and Mrs. Janet Burgoon, treasurer.

Prize Offered for Poster to Advertise International Congress

In connection with the international hospital congress to be held in June, 1929, the American Express Company, which has been designed by the International Executive Committee as the official agent of travel, has offered a prize, not to exceed \$150 for a poster that will advertise the international congress. The International Executive Committee, at a meeting to be held in Paris on August 29, will select the prize poster from among those submitted.

Louisiana Holds Fourth Annual Hospital Meeting

The fourth annual meeting of the Louisiana Hospital Association was held at the Southern Baptist Hospital, New Orleans, April 18.

The opening address was delivered by Dr. J. H. Musser, professor of medicine, Tulane University, New Orleans. An instructive talk was given by Herman Moyse, attorney, Baton Rouge, in which he explained the Workmen's Compensation Act, which is of vital concern to every hospital in Louisiana.

Charles J. Rivet, attorney, New Orleans, gave an inspiring talk on the value of the hospital to the community. A brief summary of the hospital problems discussed at the last American Hospital Association convention, was presented by Dr. John D. Spelman, superintendent, Touro Infirmary, New Orleans.

Dr. H. W. Kostmayer explained the work of the Committee for the Grading of Nursing Schools.

The principal features of the round table which was conducted by Dr. W. W. Leake, superintendent, Charity Hospital, New Orleans, were the consideration of the nursing situation in its relation to the hospital and the discussion of the compensation law. At the business session a special committee on legislation was appointed to consider an amendment to the Workmen's Compensation Act, whereby the doctor and hospital would be more fully protected.

A luncheon was served to the delegates by the courtesy of the Southern Baptist Hospital.

The new officers elected were: Annie L. Smith, Our Lady of the Lake Sanitarium, Baton Rouge, president; Dr. Louis Bristow, Southern Baptist Hospital, New Orleans, vice-president; Sister Kostka, Charity Hospital, New Orleans, secretary-treasurer.

Coming Meetings

American College of Surgeons.

President, Dr. George David Stewart, New York.
Director General, Dr. Franklin H. Martin, 40 East Erie street, Chicago.
Next meeting, Boston, Oct. 8-12.

American Dietetic Association.

President, Florence Smith, St. Mary's Hospital, Rochester, Minn.
Business Manager, Dorothy B. Richmond, 25 East Washington Street, Chicago.
Next meeting, Washington, D. C., Oct. 29-31.

American Hospital Association.

President, Dr. Joseph C. Doane, Medical Director, Philadelphia General Hospital, Philadelphia.
Executive-Secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, San Francisco, Aug. 6-10.

American Medical Association.

President, Dr. Jabez N. Jackson, Argyle Building, Kansas City, Mo.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next meeting, Minneapolis, Minn., June 11-15.

American Nurses Association.

President, S. Lillian Clayton, R.N., Philadelphia General Hospital, Philadelphia.
Headquarters Director, Janet M. Geister, 370 Seventh Avenue, New York.
Next meeting, Louisville, Ky., June 4-9.

American Occupational Therapy Association.

President, T. B. Kidner, 155 East Forty-second Street, New York.
Secretary, Eleanor Clarke Slagle, 175 Fifth Avenue, New York.
Next meeting, San Francisco, Aug. 6-10.

American Protestant Hospital Association.

President, Rev. H. L. Fritschel, Milwaukee Hospital, Milwaukee, Wis.
Secretary-Treasurer, Dr. Frank C. English, 2635 Erie Avenue, Hyde Park, Cincinnati.
Next meeting, San Francisco, Cal., Aug. 4-6.

American Psychiatric Association.

President, Dr. Adolph Meyer, Johns Hopkins University, Baltimore, Md.
Secretary, Dr. Earl D. Bond, 4401 Market Street, Philadelphia.
Next meeting, Minneapolis, June 5-8.

American Public Health Association.

President, Dr. Herman N. Bundesen, Chicago.
Executive-Secretary, Homer N. Calver, 370 Seventh Avenue, New York.
Next meeting, Chicago, Oct. 15-19.

American Sanatorium Association.

President, Dr. Henry Boswell, Jr., Sanatorium, Miss.
Secretary, Dr. Walter H. Rathburn, Cassadaga, N. Y.
Next meeting, Portland, Ore., June 18.

Canadian Nurses' Association.

President, M. F. Gray, University of British Columbia, Vancouver.
Executive-Secretary, Jean S. Wilson, 511 Boyd Building, Winnipeg.
Next meeting, Winnipeg, July 3-4.

Catholic Hospital Association of the U. S. and Canada.

President, Rev. C. B. Moulinier, 124 Thirteenth Street, Milwaukee, Wis.
Secretary, Sister M. Bernadette, 124 Thirteenth Street, Milwaukee, Wis.
Next meeting, Cincinnati, June 18-22.

Children's Hospital Association of America.

President, Robert C. Neff, University Hospital, Iowa City, Iowa.
Secretary-Treasurer, Bena M. Henderson, Milwaukee, Children's Hospital, Milwaukee, Wis.

National League of Nursing Education.

President, Carrie M. Hall, Peter Brent Brigham Hospital, Boston.
Executive-Secretary, Blanche Pfefferkorn, 570 Seventh Avenue, New York.
Next meeting, Louisville, Ky., June 4-9.

National Organization for Public Health Nursing.

President, Mrs. Anne L. Hansen, 181 Franklin Street, Buffalo, N. Y.
Director, Jane C. Allen, 370 Seventh Avenue, New York.
Next meeting, Louisville, Ky., June 4-8.

National Tuberculosis Association.

President, Dr. H. Longstreet Taylor, Children's Preventorium, St. Paul, Minn.
Managing Director, Linsley R. Williams, 370 Seventh Avenue, New York.
Next meeting, Portland, Ore., June 18-20.

Ice Water Does Not Satisfy

It may quench the thirst, but does not satisfy the palate. How much more refreshing and invigorating is a cold fruit drink on a hot, sultry day?

*Eliminate the high cost, the waste and the trouble
of squeezing whole fruit by using*

J-L-E BEVERAGE CRYSTALS

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These attractive fruit drinks with a zestful flavor, not only relieve the monotonous routine of broth and milk service, but stimulate the patients' appetite and induce them to eat other foods.

A refreshing variety to tempt the most jaded taste.

Write for samples.

Now used in the largest hospitals and institutions.

Besides being a delicious thirst-quencher, *J-L-E Beverage Crystals* satisfy the palate and furnish an ideal way of relieving the monotony of the liquid diet.

Wholesome, healthful and refreshing.

An excellent palliative when nurses pass cathartics and unpleasant medicines.

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Effect a large saving in fruit at a time when it is most expensive.

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Among the Associations

Large Attendance Expected at Catholic Convention

THE Catholic Hospital Association announces that its plans and program for the forthcoming thirteenth annual convention at Cincinnati, to be held June 18 to 22, are substantially complete. The professional program, under the direction of Dr. John R. Hughes, general chairman, was issued in tentative form on April 28, to some ten thousand hospitals, doctors, nurses and hospital executives throughout the United States, Canada and abroad.

A group of strong local committees has been formed at Cincinnati to attract professional participation by the Cincinnati hospitals which have achieved a national reputation. Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, is chairman of the local professional committee, and is cooperating with the executive committee of the association for a group of general and scientific meetings, also for local inspection trips to the various hospitals of the district. There will be ten

clinics representing the principal departments of the modern general hospital, completely equipped by leading corporations of the field, and these will be used as a background for important discussions of the pressing problems in each hospital service. The clinical group will be perhaps the most elaborate, complete and beautiful display of hospital activities ever attempted in the United States.

Participating with the Catholic Hospital Association in this meeting will be important medical and hospital associations, who will add representative exhibits portraying their respective activities. Many other organizations, while not represented by exhibits, will be represented by delegates and participants in the convention program and discussions.

This convention has received intensive and widespread publicity for the past four months, and is attracting unusual interest throughout the United States. It is expected that the attendance will be the largest in the history of the association, and that the convention, physically and professionally, will rank with any meeting ever held in American hospital history.

A World Social Meet

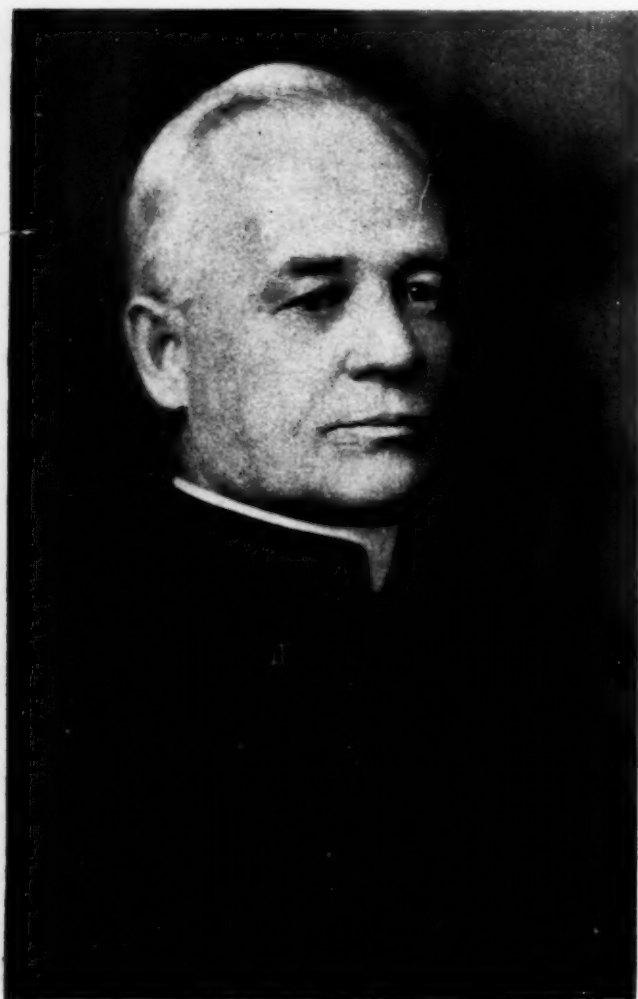
The International Conference of Social Work will be held in Paris, France, July 8 to 13. The meetings will be held in the Conservatoire des Arts et des Métiers. The conservatoire will be also the headquarters of the International Congress for Child Welfare and the International Congress for Public and Private Welfare, which precede the International Conference of Social Work. The International Housing Congress will be held at the Sorbonne. These Congresses together with the International Conference of Social Work constitute the International Social Welfare Fortnight running from July 2 to July 13. It will be an outstanding event in the history of social work.

T. B. Association to Meet on West Coast

The twenty-fourth annual meeting of the National Tuberculosis Association will be held in Portland, Ore., June 19 to 21.

The program is to be divided into four major parts: pathological, clinical, sociological and administrative. Special sessions are to be held for each division. In addition to the formal program there will be meetings of the American Sanatorium Association and the Pacific Coast section of the American Public Health Association. There will also be a nurses' conference and a child health education conference.

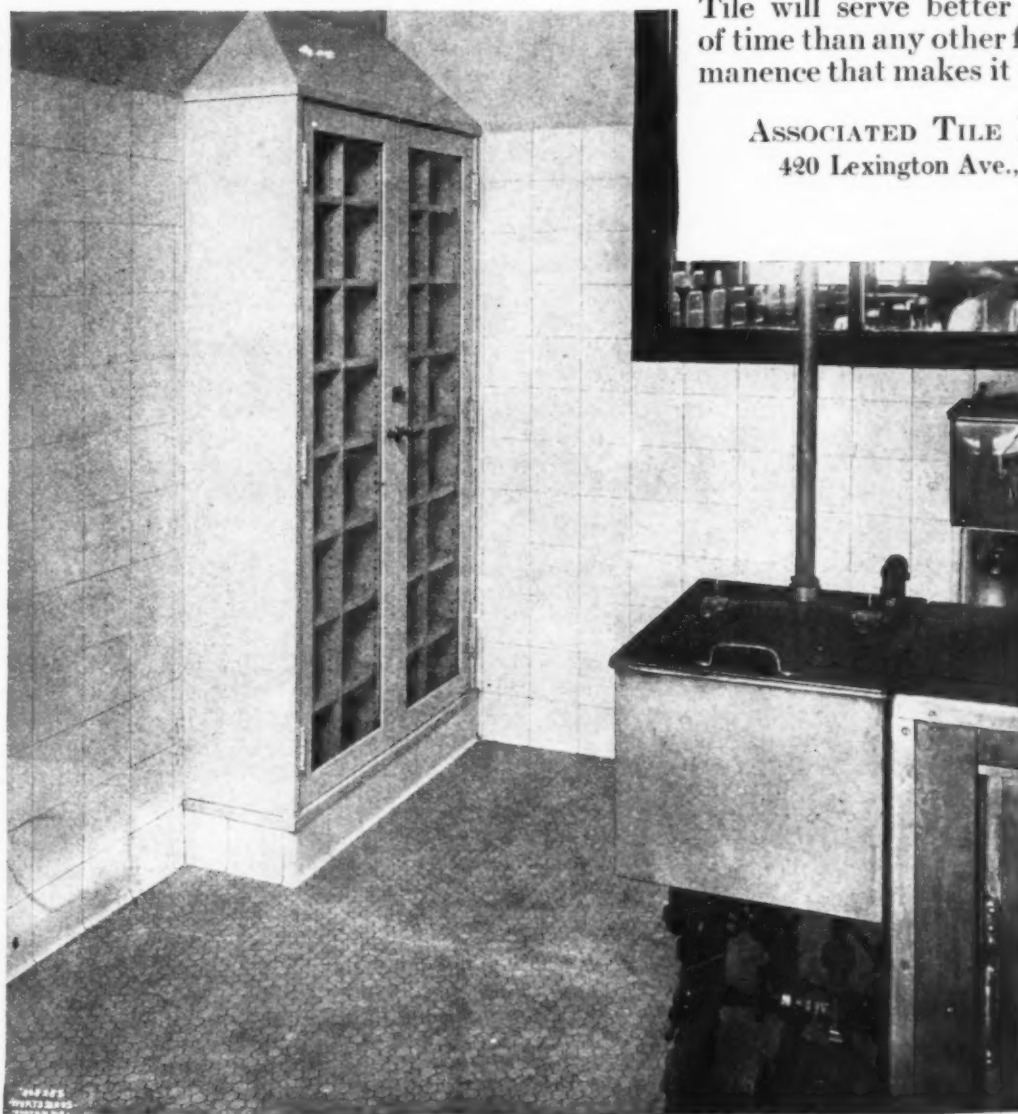
Friday, June 22, is the day set aside for recreation and an interesting excursion is promised up the Columbia River Highway, and around the base of Mount Hood.



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K E R A M I C T I L E S

For complete index of advertisements refer to the Classified Directory

Among the Associations

Meeting of N. C. Association Held at New Bern

One of the most comprehensive programs ever arranged by the North Carolina Hospital Association was presented to the delegates at the annual convention held at New Bern, May 16, 17 and 18. Visitors were registered from various points throughout the United States and Canada, and the meeting was proclaimed most successful.

At the opening meeting of the convention, held Wednesday evening, May 16, addresses of welcome were made by A. H. Bangert, mayor of New Bern, and Dr. R. Duvall Jones, superintendent, St. Luke's Hospital, New Bern. The meeting was concluded with an address by the president of the association, Dr. C. S. Lawrence, Winston-Salem.

Some of the interesting papers at later sessions dealt with the following subjects: problems in the laundry, by W. S. Cox, manager, Rex Hospital, Raleigh; standards and buying in hospital practice, by Maj. Walter L. Simpson, superintendent, Watts Hospital, Durham; the orthopedic hospital and its relations to other hospitals in the state, by Dr. O. L. Miller, surgeon in charge, North Carolina Orthopedic Hospital, Gastonia; the daily schedule of the student nurse, by Ora Longley, Highsmith Hospital, Fayetteville; the evolution of a private hospital into a community hospital under the Duke Endowment plan, by M. E. Winston, business manager, Park View Hospital, Rocky Mount; the maintenance of the laboratory, by Dr. O. E. Finch, Mary Elizabeth Hospital, Raleigh; the relation of the state department of public welfare to the hospitals in North Carolina, by Mrs. Kate Burr Johnson, and case histories and hospital records, by Mrs. C. L. Sheets, historian, Lawrence Hospital, Winston-Salem.

Round Table Featured

At the Thursday afternoon session, presided over by Lula West, superintendent, Martin Memorial Hospital, Mount Airy, vice-president of the association, a round table discussion of hospital problems was conducted. At this meeting Dr. W. S. Rankin, of the Duke Endowment, Charlotte, gave a report of the work done by the Endowment.

Dr. Jones presided over the Thursday evening meeting which was devoted to a discussion of the mutual interests of the hospital, the community and the Duke Endowment. The speakers on this program were Col. John Langston, Goldsboro; Dr. Charles O. Laughinghouse, secretary, State Board of Health, Raleigh, and Dr. Rankin.

At the Friday morning session a report was made by Dr. Davison, dean of the medical department, Duke University, Durham, on the development of a hospital and medical school at Duke University, and the special committee on standardization in the hospital also presented a report.

The natural beauties of the country added a great deal toward the pleasure and entertainment of the delegates. A delightful trip was made down the Neuse River aboard the United States coast guard ship, *Pamlico*; and the

country club was thrown open to those who preferred golf. New Bern is in itself a point of great interest, being one of the small towns that was historically important in the early development of the country.

Plans for Protestant Convention Near Completion

Preparations for the American Protestant Hospital Convention at San Francisco are progressing rapidly. Dr. Frank C. English, executive secretary of the association, is arranging for groups of delegates to assemble at strategic geographical points to take special trains, as far as practical, to the national parks and scenic attractions, en route to the convention and on their return home.

Protestant hospital executives and workers are enthusiastic about the convention on the Pacific coast, many regarding this as an unusual opportunity to combine sight-seeing and pleasure with the business and intellectual inspiration of the hospital convention. Judging from reports received by the secretary it is expected that the Protestant association will hold its largest convention in San Francisco, August 3 to 6.

The Northern Route

Those who wish to visit the Northwest, via the Burlington and Northern Pacific Railway, will take the "Yellowstone Comet," Burlington Railway, Chicago, Monday, July 23, at 10:35 a. m., arrive at Yellowstone Park, July 25, spend four and one-half days in the Park, arrive at Seattle, Wash., or Portland, Ore., July 31, visit points of interest on the Coast, and arrive at San Francisco for the opening of the convention, August 3. The fare over this route, from Chicago to San Francisco, and return by any route selected is \$108.30; Pullman lower berth going, \$33.75.

Those going by the central route will leave Chicago, July 29, at 10:30 a. m., via the Burlington, stopping at Denver and Colorado Springs, and having a daylight ride through the Royal Gorge, and Feather River Canyon, stopping at Salt Lake City, and arriving at San Francisco, August 3, at 7:30 a. m. The fare over this route from Chicago to San Francisco and return by any route selected is \$90.30; Pullman lower berth going, \$23.63.

Round trip fares: from New York City, \$138.32, Pullman \$32.63; from New Orleans \$100.50, Pullman \$21.00; Philadelphia \$133.14, Pullman \$31.50; Washington, D. C., \$130.45, Pullman \$31.50; Pittsburgh \$113.05, Pullman \$28.13; Cincinnati \$101.35, Pullman \$26.25; St. Louis \$85.60, Pullman \$22.50; Minneapolis \$91.90, Pullman \$23.63.

After the Protestant and American conventions, parties will be formed to return over several routes. It is recommended that a part of the Protestant delegation take the Southern Pacific to Yosemite Valley, then visit Los Angeles, and take the Santa Fe Railway from Los Angeles at 11 a. m., arriving at the Grand Canyon the following morning, and possibly take the Indian Detour on their return trip home.



*K*ARO is the Corn Syrup now being prescribed by leading Pediatricists for Infant Feeding not only because of its uniform high quality but because parents can secure it from grocers throughout the United States.

Both Blue Label and Red Label Karo are recommended—we suggest the smaller or 1½ lb. can for more convenient use.

Personals

WILFRED E. CHAMBERS has succeeded EDWIN J. ROSE as superintendent of the United States Veterans' Hospital, Kansas City, Mo. Mr. Chambers was formerly at the United States Veterans' Hospital, Excelsior Springs, Mo. DR. THOMAS F. NEIL is now in charge of the Excelsior Springs Hospital.

DR. FREDERICK R. SIMS has left the United States Veterans' Hospital, North Little Rock, Ark., and his place has been filled by DR. HENRY L. STICK, who was formerly in charge of the Veterans' Hospital, Philadelphia. DR. GEORGE M. MELVIN who was superintendent of the Veterans' Hospital, North Chicago, Ill., has taken Dr. Stick's post at Philadelphia, while DR. O. G. WILLHITE has taken charge of the hospital in North Chicago.

DR. EUCLID B. FRICK has been obliged by ill health to resign his position as superintendent of the San Francisco Hospital, San Francisco. His successor has not as yet been appointed.

DR. HUGH J. STRATHEARN, formerly a member of the staff of the Hollywood Hospital, Hollywood, Calif., has recently been appointed medical director of the Catalina Hospital, Catalina Island. The growth of the resident population of the island has necessitated the making of certain improvements in the old hospital building.

DR. EDWIN O. PALMER was recently appointed business manager and superintendent of the Hollywood Hospital, Hollywood, Calif., succeeding DR. THOMAS R. PONTON who is now associated with the Gorgas Memorial Institute, Chicago.

DR. SOLOMON SOLIS COHEN has accepted the position of medical director of the new Jewish Convalescent Home which is to be built at Willow Grove, Pa. The old home in Andalusia will be destroyed.

DR. CHESTER A. MARSH, Hagerstown, Ind., has recently been appointed superintendent of the state colony for epileptics at Selins Grove, Pa. Three buildings of the colony are under construction and will be finished this year.

DR. F. S. WILCOX, who for a number of years has been superintendent of the Norwich State Hospital, Norwich, Conn., has recently handed in his resignation, and will establish a private sanatorium in Easton, Pa., according to reports.

DR. GARNET P. SMITH has accepted an appointment as superintendent of the Bristol County Tuberculosis Hospital, Attleboro, Mass. Dr. Smith will be the successor of the late Dr. Adam S. MacKnight, who died last February.

MRS. EDNA KNIGHT has resigned her position as assistant superintendent of the Tampa Hospital, Tampa, Fla.

DR. ELIJAH S. BURDSALL has accepted the appointment of superintendent of the Norwich State Hospital, Norwich, Conn. Dr. Burdsall is filling a vacancy left by DR. F. S. WILCOX.

NELS HANSHUS has recently been appointed manager of the Luther Hospital, Eau Claire, Wis. SIGRID ESVAL, R.N., had been temporary manager prior to Mr. Hanshus' appointment.

LETHA CHADWELL has resigned as superintendent of the La Salle County Tuberculosis Sanatorium, Ottawa, Ill., and will accept a position with the Municipal Tuberculosis Sanatorium, Rockford, Ill. CORNELIA ELLIOT, formerly assistant superintendent of the La Salle County Sanatorium, has accepted the appointment as superintendent at that institution.

AMY G. HORST has resigned her position as general superintendent of the Morningside Hospital, Tulsa, Okla., and has accepted an appointment as superintendent of the Grand View Hospital, Sellersville, Pa., where she will succeed CLARA M. BRUNNER. The vacancy in the Tulsa hospital has not as yet been filled.

SARAH BITLER, for the past three years superintendent of the Bloomsburg Hospital, Bloomsburg, Pa., has been engaged to take the place of DORIS CHRISTESON as superintendent of the Jersey Shore Hospital, Jersey Shore, Pa. MARION E. SMITH is the new superintendent of the Bloomsburg Hospital.

GRACE SHUPING has been appointed superintendent of the Hillsboro Hospital, Hillsboro, Ill., to fill a vacancy left through the resignation of HATTIE LEWIS. Miss Lewis has gone to Ohio to take an advanced course in anesthesia.

L. A. SANDERS, who has announced his resignation as superintendent of the West Texas Baptist Sanitarium, Abilene, Tex., is going to Dallas, Tex., to take charge of the Medical Arts Diagnostic Hospital. A successor to Mr. Sanders has not as yet been appointed.

FRANCES P. WEST has resigned as superintendent of the Beverly Hospital, Beverly, Mass., and has accepted a similar position at the Charlotte Hungerford Hospital, Torrington, Conn., where she is succeeding Louise F. McLeod.

DR. GEORGE F. BREWSTER formerly in charge of the United States Veterans' Hospital, New York, has been transferred to the Veterans' Hospital at Northport, L. I., where he will hold a similar position.

CAROLYN E. DAVIS, formerly superintendent of the Minor Hospital, Seattle, Wash., has resigned to accept a similar position at the General Hospital of Everett, Everett, Wash. She is filling a vacancy left by Ella W. Harrison.

MAY L. LOVE has resigned as superintendent of the Litchfield County Hospital, Winsted, Conn. Her position has been temporarily taken over by AMELIA SMITH while the board of trustees is deliberating over the appointment of a permanent superintendent.

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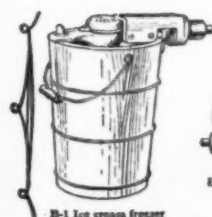
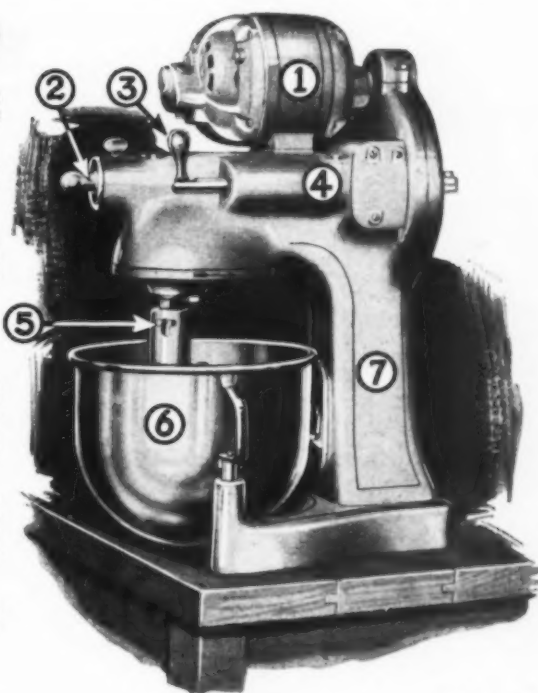
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B-5 Mayonnaise oil drip



B-6 Tool sharpener



B-7 Fruit juice extractor for lemon, orange and grapefruit



B-8 Coffee and spice grinder

News of the Month

New Clinic in Bronchoscopy Now Open

A new bronchoscopic clinic, containing the latest and most complete facilities for carrying on all clinical and instructional work in bronchoscopy, was recently opened for public service in the Graduate Hospital of the University of Pennsylvania, Philadelphia, with Dr. Chevalier Jackson, who developed the bronchoscope, in personal charge. The department was fully equipped through the generosity of Frederick S. Bigelow, a member of the board of managers of the hospital.

In addition to its own complete equipment, the clinic is served by the private and ward beds, the medical and x-ray laboratories, and complete consultation facilities of the new \$2,000,000 hospital.

Bronchoscopy, when it was first developed, was used and thought of mainly as a means of removing foreign bodies from the lungs, but in later developments and as at present used, it is applied to the examination of the bronchial cavities and passages with electrically lighted instruments.

Besides the free work the clinic is doing in the community, postgraduate classes in bronchoscopy are held for physicians who wish to make a study of this subject.

New Henrotin Hospital to Cost \$2,500,000

The new Henrotin Hospital, Chicago, is to cost \$2,500,000 according to the latest advices from those interested in its construction. The street widening of La Salle Street has hastened the work on this project and it is stated that the new building will be ready for occupancy before it becomes necessary to tear down the present structure. The Henrotin Hospital when completed will be one of the outstanding institutions in Chicago.

Pennsylvania Upholds High Medical Standards

The following resolution was unanimously adopted by the Philadelphia Hospital Association at its meeting on April 18, 1928:

The Philadelphia Hospital Association approves of the efforts of the joint conference committee, representing the Hospital Association of Pennsylvania, the Medical Society of the State of Pennsylvania, the Homeopathic State Medical Society and the Eclectic State Medical Society, to prevent any lowering of the standards required for practicing the healing arts, now covered by the Medical Practice Act of 1911, for the following reasons:

First: That the existing act provides for the legal licensing of every known kind of practitioner, irrespective of what he may call himself or the school of treatment to which he is supposed to limit his practice.

Second: The sincere belief that the legislature should

consider only measures for the protection of the public, and should not consider any special legislation for the protection of physicians, osteopaths, chiropractors, naturopaths, etc.

The Philadelphia Hospital Association pledges itself to oppose any efforts to lower the present standard of requirements for the education and licensure of persons seeking to practice the healing arts in this state.

Knighthood Reward for Services in India

Dr. William J. Wanless, Miraj Hospital, Miraj, India, in recognition of his services to that country, has had the honor of knighthood conferred upon him by King George V of England. In 1898, Dr. Wanless went to India and established a dispensary in a small building in Miraj, where, in two years, he treated about 8,000 patients. During the last thirty years the institution has grown steadily, and at the present time, there are more than twenty buildings connected with the hospital. It is said to be the only mission school in India that trains men in medicine. For a number of years the institution has been self-supporting.

Dr. Wanless is a graduate of the medical department of New York University. He is retiring from service in India, and will make his home in Glendale, Calif. Dr. Charles E. Vail, a graduate of Columbia University, will succeed Dr. Wanless in Miraj.

San Francisco to Have New \$500,000 Hospital by July

The maternity wing, a four-story addition to the Children's Hospital of San Francisco, is well on its way toward completion. The women's auxiliary of this hospital has been in a large way responsible for the building of the addition, in that a great part of the half-million dollars required for the addition was the proceeds of its annual Mardi Gras carnival. Besides enabling the hospital to build an addition to the main building, the auxiliary, by its wonderful support, has made it possible for the hospital to carry on approximately \$90,000 worth of charity work annually.

Commonwealth Fund Aids Hospitals

The board of directors of the Commonwealth Fund at a recent meeting appropriated \$358,438 for the Fund's rural hospital program. During the last two years five awards have been made under this program, for hospitals in Farmville, Va., Glasgow, Ky., Farmington, Md., Beloit, Kans., and Wauseon, Ohio. In each case the Commonwealth Fund provides two-thirds of the cost of construction and equipment, while the community pays the remainder of the cost and assumes the expense of operation.

Another appropriation made at the meeting provided \$3,800 for the cardiac clinic of the Johns Hopkins University Hospital, Baltimore.

How ICE serves and saves in Hospitals

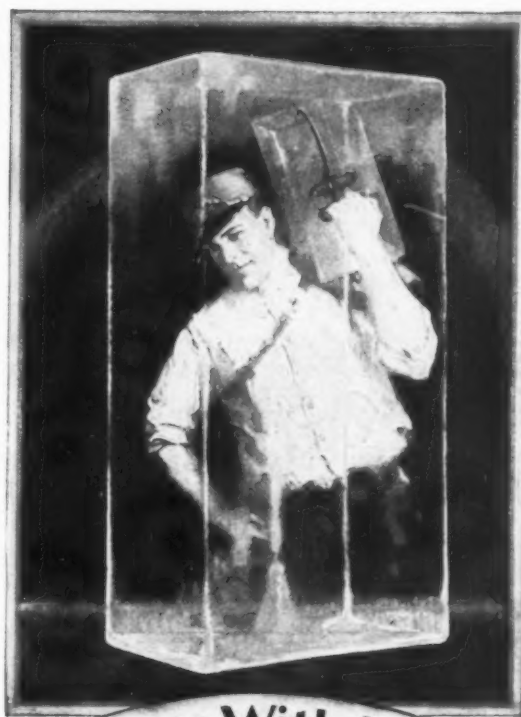
FROM 25 per cent to 35 per cent of the hospital dollar is spent for food. Solely from a dollar-and-cents standpoint, the service of ice in saving food yields a big profit on the investment.

Ice in a good refrigerator keeps food at its best. Food is served to the patients in prime condition—meats with all of their full-flavored juices intact—vegetables as fresh and crisp as when gathered—fruits with their precious, elusive, natural flavors at the highest point of perfection.

The air in a refrigerator is purified by its constant circulation over the ice. Impurities and odors are borne to and absorbed by the film of moisture on the ice cake and carried off in meltage through the outlet. It takes melting ice and an open outlet to do this.

But the perfect refrigeration of perishable food, important as it may be, is only part of the service which ice renders in the modern hospital.

The therapeutic value of ice lifts it to a major place in the service of medi-



Save With Ice

cal science. Ice is employed by physicians and surgeons in innumerable ways—to ease pain—to allay inflammation—to reduce temperatures in fevers, et cetera.

The hospital as a community health center as well as an institution for the care of the sick, is doing much to direct public attention to the importance of the more extensive use of ice as a protection against various diseases which are caused by failure to refrigerate foods in hot weather.



News of the Month

New Children's Building of Cook County Hospital to Open Soon

The new children's building of the Cook County Hospital, Chicago, is nearly ready for occupancy. Completion of this building will add 500 beds for children, and raise the total capacity of the hospital to 3,200 patients. The addition has cost the county nearly \$1,000,000, and has raised the total value of Cook County Hospital property to about \$14,000,000. The fifth and sixth floors of the new building are to be left unfinished for the present, and the seventh floor has playrooms, schoolrooms and a physical therapy laboratory. A lecture room accommodating 100 has been provided. The building is connected with the general hospital by means of a tunnel.

Abington Memorial Hospital to Have Five New Buildings

The building program for the Abington Memorial Hospital, part of the old York Hospital, Norristown, Pa., includes the construction of five new buildings. The present bed capacity of 165, will be raised to 300. There will be, in addition to this, a new administration building, a nurses' home, an operating building and a combined help's dormitory and power house.

The hospital was founded by the late John W. Elkins, as a memorial to his wife, and has benefited from time to time by contributions from him. Money for this project was made available by medium of a drive nearly a year ago, in which \$1,500,000 was subscribed.

American Public Health Association to Meet in Chicago

The fifty-seventh annual meeting of the American Public Health Association will be held in Chicago, October 15 to 19, with headquarters at the Hotel Stevens. The American Child Health Association and the American Social Hygiene Association will meet with this organization.

Dr. Louis E. Schmidt is chairman of the local committee and Arthur E. Gorman is secretary. Sessions are being arranged for health officers, child hygienists, public health nurses, laboratory technicians, vital statisticians, health education directors, food and drug experts, industrial hygienists and public health engineers.

New York Spends \$45,700,000 on Hospitals in 1927

New construction in hospitals in New York City has cost about \$45,700,000 in 1927, according to the *Boston Medical and Surgical Journal*. Of this sum, the largest

individual project is the New York Hospital—Cornell Medical College Association, which calls for the expenditure of \$15,500,000 for a new medical center on the East River.

Five million dollars has been expended for Lenox Hill Hospital; \$2,500,000 for Lebanon; \$2,000,000 for the Italian Hospital and \$1,500,000 for St. Elizabeth's Hospital.

In Brooklyn, ten projects were undertaken and the amounts spent were \$2,500,000 for the Jewish Hospital, \$1,500,000 for the Methodist Episcopal, \$1,500,000 for the Brooklyn Eye and Ear Hospital, and \$1,000,000 for each of the following: Brownsville and East New York Hospital and St. John's Hospital, Long Island.

Institute for Nurses to Be Held in Chicago

The sixth annual institute for nurses, conducted by the Illinois League of Nursing Education, will be held in Chicago during the last two weeks of June. A comprehensive program is being planned so that the nurses in the various fields of nursing will find an abundance of material which will be of great educational value to them in their work.

Two courses of lectures will be given. One will deal with teaching in schools of nursing, psychology, sociology and effective speaking; the other will consist of a series of special lectures and demonstrations, held at various hospitals in the city. In this second series, experts in their special fields will be selected to deliver the lectures, so that those who attend the institute will have the privilege of hearing and meeting some of the most eminent men and women of the nursing profession who will be present.

A special feature of the program will be a course of lectures in psychology by Dr. William E. Blatz, professor of psychology, University of Toronto, Ont.

Florida Hospital Holds Clinics for Colored Doctors

Approximately forty colored physicians of Florida and neighboring states attended the surgical clinics held recently at Duval County Hospital, Jacksonville, Fla., according to the report of Fred M. Walker, superintendent of that institution. These clinics were arranged by the regular medical staff of the hospital as a postgraduate course of instruction to the colored doctors of that part of the country, to enable them to improve their service to patients of their race. About twenty members of the staff took part in the various clinics.

Ten patients of the hospital's regular colored wards underwent necessary operations, performed by representative surgeons of the organized medical staff in the course of these four-hour clinics. Other physicians gave demonstrations and lectures.

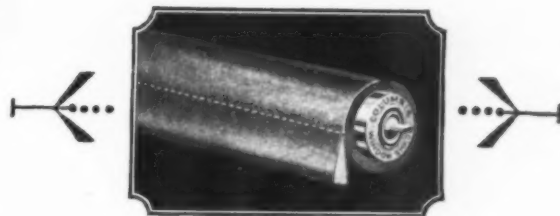
All activities of the hospital are under the control of the Duval County Welfare Board.

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Photo by Oren Jack Turner



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NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

How Can We Best Meet Economic Problems of Nursing Education?*

By M. ADELAIDE NUTTING

New York

WHEN we come to review the history of nursing for the past half century we shall find, I think, that its most significant, and certainly its most interesting pages are those that tell of the efforts to improve the education of nurses.

These will be found in the issues of our various nursing periodicals, beginning with the *British Journal of Nursing*, in the reports of our nursing associations, in the records of our schools of nursing and of hospitals, and in the laws concerning the training of nurses, which are now upon the statute books of a good many countries. From even a casual study of these records there emerges a picture of long sustained, patient, laborious efforts to bring about improvements in training schools for nurses, that can have few parallels in the history of education—certainly none within modern times.

It should first be pointed out that the period during which these efforts have been carried on, has been marked by great advances in science. The driving power of its discoveries upon medical and surgical practice and research has resulted in a truly enormous development of hospitals, and later of organized measures for the prevention of disease, and the protection of health. With the multiplication of hospitals of many types, and with the increasing complexity of their tasks, the demands upon the knowledge and ability of nurses, have become progressively exacting and difficult to meet.

In the public health movement nurses are everywhere drawn into new and wider ranges of duties and responsibilities. In the hard task of securing the continuous and intelligent cooperation of man in his own deliverance from disease, they are accorded a strategically important share. These expansions in the old fields, these developments of new fields of nursing, have set up new conditions and requirements in the education of nurses. They have made steadily enlarging demands upon schools of nursing for improvements in every phase of their work. They have created a need for women of higher education and intelligence, capable not only of giving satisfactory service in the fields of their activity, but with capacity to grow, with a foundation upon which

something further can be built, for there must be leaders in public health work, administrators in schools of nursing, teachers of the coming generations of nurses.

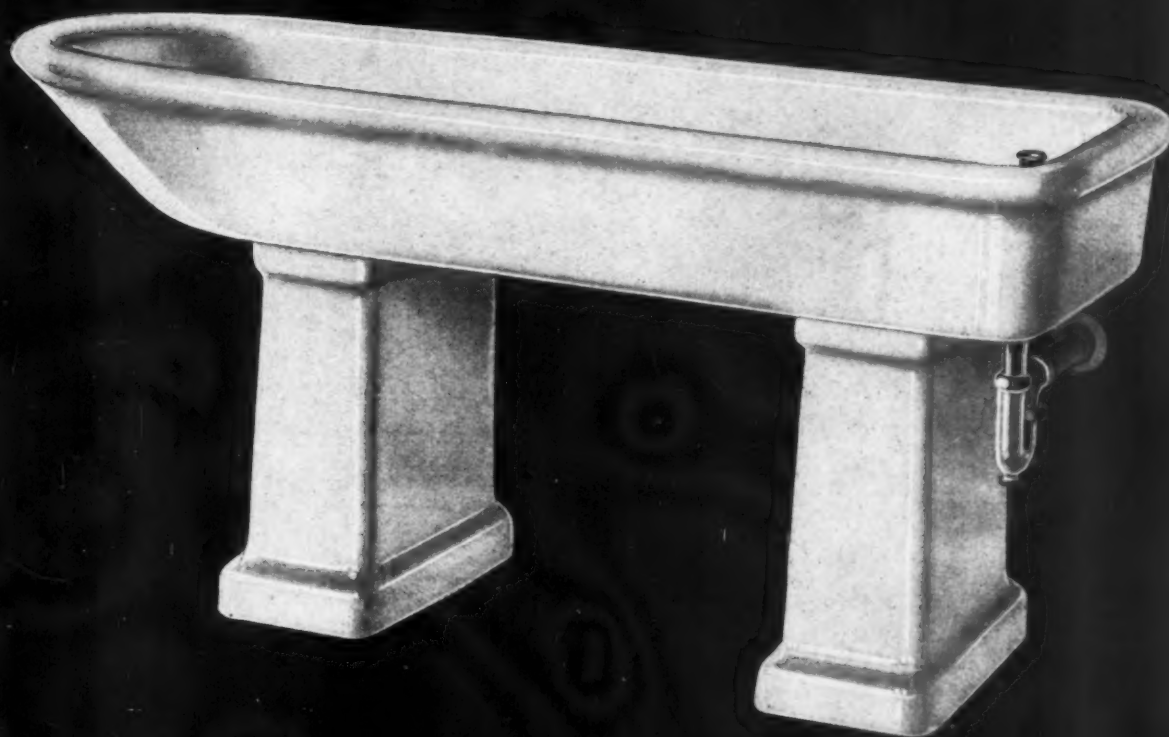
It is evident that schools of nursing have made great efforts to lift themselves to the height of these new opportunities. They have struggled to provide better facilities for teaching, to secure better equipped teachers and a more adequate scheme of instruction. They have tried to shorten the hours of hospital duty for students, and to improve their living conditions. Yet with fullest recognition of all that has been so far accomplished, it must be admitted that their progress has been slow and halting, and that schools of nursing are in most ways conspicuously behind other forms of professional education. I am sure that to those who are acquainted with earlier conditions in our schools, and who have labored untiringly to secure every small improvement that has been made, the gains will seem large, but to the world outside, familiar with the advances made in other educational fields, our achievements do not seem impressive. To some, indeed, they seem pitifully small.

Training School Standards Should Be Raised

In an exhaustive study of the education of nurses,¹ made recently by an important committee of doctors, nurses and public health workers, the situation was thoughtfully discussed. After pointing out that the average hospital training school is not organized on such a basis as to conform to the standards accepted in other educational fields, the report goes on to say: "The educational needs and the health and strength of student nurses are frequently sacrificed to practical hospital exigencies." It calls attention to "the long hours of duty in hospitals," to the "excessive and unproductive night duty," to the "crowded and unattractive living conditions for students," and to the "pervading atmosphere of autocratic discipline." It also calls attention to the "deplorable turnover" among the executive officers of these schools, where in one state with 144 schools, sixty had changed superintendents at least once during a single year.

*Reprinted from the July, 1927, issue of the I. C. N.

¹ "Nursing and Nursing Education in the United States." Report of the Committee for the Study of Nursing Education. The Macmillan Company, New York, 1923.



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A more recent study of the North Atlantic states shows that "out of 502 nursing schools, 248, or almost exactly 50 per cent have changed their superintendents of nurses within the past two years," adding that "this proportion holds just about the same all over the country."

Those who know the situation, know that many of these heads of schools retire with a deep sense of discouragement and helplessness in the face of difficulties and obstacles which under present conditions seem to be insurmountable. Many of these obstacles ought not to exist. They would not be found in other educational systems.

There have been, however, two notable advances in the education of nurses. These are, first, the movement of nursing schools toward the university and, second, the beginnings of endowments for nursing education.

The former began in 1899, when Teachers College, Columbia University, New York, first admitted qualified graduate nurses, giving them some college credit for a certain proportion of their nursing training. A decade later the first school of nursing as part of a university system was established in the University of Minnesota, and this lead has been followed by about twenty-five other colleges and universities in this country, and by a few in other countries.

Accompanying this development of relationships with universities, and in a sense the outcome of it, has been the bringing forth of the idea that financial support is necessary for the education of nurses, and the beginnings of endowments for that purpose. These are not only the highly important advances of recent years, but must be looked upon as great events in our educational history, likely to exert a profound influence upon the future of nursing. They mark a definite stage of evolution from one system to another, a stage that has been reached in part unconsciously, one of those groping efforts to make life better, which are among the undying gleams of our guiding light.

Heads of Schools Responsible for Progress

In the report of the Committee on Nursing Education, before referred to, the work of these years and its results are interestingly summed up. "It cannot be too strongly emphasized," says the report, "that the progress that has been undeniably made in nurses' training, has been made by the nurses themselves, practically without help and without thanks. If there is today any coherent, any integrated system of training to meet the insistent public demand for nurses, it is owing mainly to the patient, constructive efforts of the heads of training schools, who have stood out against the needs of the moment in the interests of genuine instruction. It has been a progress made in the face of obstacles that would have daunted less resolute enthusiasts, in the face of indifference, or negligence and of active opposition from those who should have been the first to encourage it. It has been a progress moving squarely against the vested interests of hospitals, long in control of the destinies of nursing education."

According to statistics recently gathered by the Council on Medical Education and Hospitals of the American Medical Association, there are in America 2,155 hospital training schools, with an enrollment of 76,527 students. Here, as in most other countries, hospitals own and administer these schools, controlling their educational policies, and directing the activities of both staff and students. Schools of nursing are regular departments of hospital organization, and members of the school staff are hospital officials. Both staff and students are united to form

the regular, resident, uniformed nursing service of the hospital, and the students are subject to such demands in the care of the sick as would have to be met largely by trained, salaried nurses, were no students available. For these services the students are given training, living and an allowance for uniforms, and these, according to the printed announcements, form a full equivalent for whatever services the students render, during a period of three or sometimes four calendar years. The system has become deeply entrenched, and not only the hospital mind, but the public mind, has become indoctrinated with the idea that it is the province of hospitals to control the education of nurses.

Should Hospitals Control Nurses' Training?

Some idea of the extent to which hospitals may profit from the ownership of nursing schools, may be gained from the following statement in a letter dated November 22, 1926, which appeared in the *New York Times*, and was repeated in another letter, dated January 18, 1927. The letter is from an official connected with a campaign for funds for a New York hospital and medical school. It asks for the sum of \$500,000 with which to erect a nurses' home and training school in ground adjoining the hospital building, and says that this "will increase our nursing service by adding 200 nurses, and our teaching service by training them, and will save \$60,000 a year in hospital maintenance expense."

Clearly the root problem in our schools of nursing is a financial one. This phase of our educational system has nowhere as yet been seriously grappled with. The financial benefits derived by hospitals from the control of nursing schools, no one has as yet made any serious attempt to estimate. It is obviously important that this whole economic relationship should become the subject of careful inquiry, conducted by persons unrelated to hospitals, nursing or medicine, and concerned only in getting the facts and in seeing that they are correctly interpreted. A similar study should, of course, be made concurrently of the benefits, financial and otherwise, that the school of nursing derives from its connection with the hospital.

We should not fail, however, to recognize certain basic factors in the present situation. Schools of nursing are avowedly created by hospitals as a means of lessening their own expenses, and with this purpose it is inevitable that the educational needs of these schools should be reduced to a minimum. Hospitals are thus freed from most of the costs of maintaining an adequate nursing service. But they are also freed from most of the costs of education which the use of the term "school" implies. There is little to prevent them from applying in their schools whatever ideas they may happen to entertain, as to a desirable minimum for the education of nurses. The only checks upon this, lie in the requirements of the laws of their states relating to this question, and these are usually very modest, or in the force of public opinion, which as yet, is not sufficiently well informed and coherent to have much influence on this matter.

The system under which the school of nursing functions today, belongs to a primitive stage of social organization. Its basis is a form of apprenticeship, centuries old, a survival of the past in striking opposition to other modern forms of education. Other educational institutions, colleges, universities, professional schools, can exist only through suitable financial support, which may come through endowments from private funds or through public funds by taxation.

Throughout Europe the latter system prevails, and universities to which most professional schools are at-

¹ "Problems Involved in the Grading Program," by May Ayres Burgess, Ph.D., *American Journal of Nursing*, Dec., 1926.

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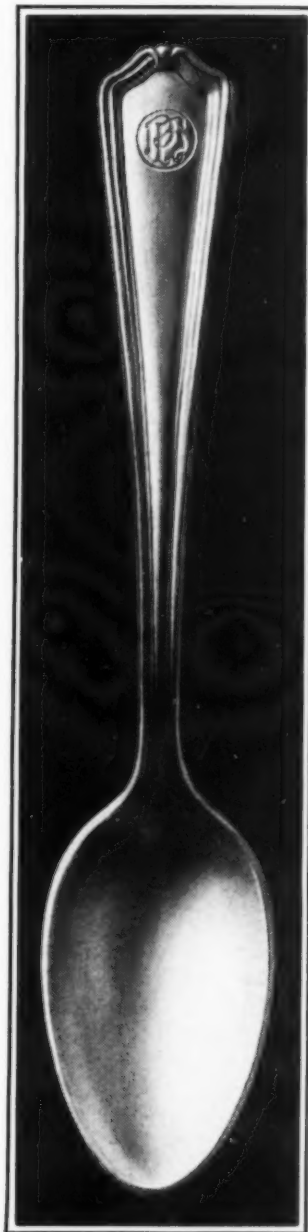
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tached, are state supported institutions. In America, the state universities are supported almost wholly by taxation, and enormous sums are appropriated yearly for them. But in Europe also there are many richly endowed universities and professional schools, and truly princely gifts are made by individuals or Foundations to many forms of higher education. Medical education, in particular, makes a strong appeal to private philanthropy, and is becoming generously endowed.

To all of these long established ways of meeting the costs of education, nursing, as has been shown, presents in its educational system a complete contrast. Yet schools of nursing did not begin that way. It would hardly have entered the astute and logical mind of Florence Nightingale, that hospitals either could or should meet the expenses necessarily involved in the education of nurses, and it is a significant fact that has been too long forgotten, that the first school of nursing in the modern world, the famous school at St. Thomas's Hospital, London, was generously endowed by Miss Nightingale. The revival of this idea within recent years is a fresh tribute to the soundness of her thinking.

We have apparently reached a stage where the trend and thought of the times are moving—slowly and hesitatingly, but still moving—somewhat away from the present system. There have long been a few schools in this country, and I presume in others, supplied, usually through committees of women, with certain funds for educational purposes that were unprovided for by the hospital. Bellevue Hospital School of Nursing in New York is a conspicuous instance of a school with a notably generous women's committee.

But the first large gift for nursing education came in 1910, when the department for graduate nurses of Teachers College, Columbia University, was endowed by a woman member of the board of trustees. This has been followed by liberal endowments for the schools of nursing connected with Yale, Western Reserve, Vanderbilt and Chicago Universities. Recently, chairs of nursing have been endowed in the Universities of California and of Virginia, and, coming through the efforts of nurses, these are of unique interest. An early effort to build up an endowment was set in motion, in 1914, by the alumnae of the Johns Hopkins Hospital School of Nursing, Baltimore, and a considerable fund has been accumulated.

Endowments Are Needed

This movement gained a strong impetus in the recommendations of the Committee on Nursing Education already mentioned. These stated that "the proper development of nursing education demanded, as an absolute prerequisite, the securing of funds for its endowment, and that it is of primary importance to provide generous endowment for the university schools of nursing." It should be noted here that the endowments so far received have all been for schools connected with universities.

While it would hardly be possible to overestimate the importance of the developments now taking place in the university education of nurses we should keep in mind that this growth is bound to be slow. For some time to come, there will be comparatively few university schools, and meanwhile we should not neglect to help forward the education of nurses in whatever ways are open to us. It should not be beyond the power of society to help hospitals, by assuming some of the burdens which they are obviously unable to carry. Side by side with those bodies of men and women, generous in giving to charitable institutions, such as hospitals, which always have difficulty in raising their budgets, there should be similar bodies

engaged in providing for the educational needs of schools of nursing, which usually have no separate budgets whatever.

The Committee on Nursing Education laid great stress on the need of such bodies. It pointed out with much emphasis, that the purposes, functions, and responsibilities of hospitals and schools of nursing are widely different, even though they may cooperate closely in certain ways to attain their several ends. "The interests of hospital management and educational policy will," the report says, "inevitably conflict, and whenever they do, the needs of the sick must predominate; the needs of education must yield." Hospital boards with their varied responsibilities are clearly unable to give first consideration to the function and needs of the schools of nursing, and therefore as a fundamental essential, there should be established bodies specially concerned with the educational policies of the school, and with conditions of student life. The committee urges that "the school of nursing must first of all be directed by a board or committee, organized more or less independently, for the purposes of education."

Unquestionably schools of nursing would derive great advantages from having properly constituted boards or committees, invested with requisite authority and responsibility, and bringing to their task the ability, energy and enthusiasms which have been so fruitfully enlisted in the cause of education elsewhere. These committees are potential sources of strength to hospitals as well as schools, and are an assurance to the public that there is some appropriate body responsibly concerned with the interests of the school.

Finally, we should not fail to note that all countries appear to be turning more and more to the public support of professional education. It is highly important for nurses living in countries where immense private fortunes may not be as common as they are in America, to realize that endowments are, after all, but one way of providing for the support of schools of nursing. These schools are as fully entitled to share in the educational opportunities provided by public funds as are other professional schools. Nursing is an essential public service, in common with medicine, law, teaching, engineering and others. The education of future generations of nurses is a matter of public concern.

The educational problems with which the International Council of Nurses is so necessarily engaged, are in considerable measure dependent upon a clearer understanding of the economic problems in nursing, and upon courageous and energetic efforts to deal with them.

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Printed forms have been made up by the St. Joseph's Hospital, Victoria, B. C., in an effort to abolish whatever confusion might take place over the discharge of a patient. Several hours before a patient is ready to leave the hospital, it is necessary for the doctor to sign the discharge note. Then a nurse under the direction of the floor supervisor fills out the required form which contains the following information: name, room, doctor, date of entering and leaving, a summary of "extras," such as anesthetic, medicine, dressings, x-ray, special nurses. The slip is signed and dated by the nurse and immediately forwarded to the accountant's office where an itemized bill is prepared. The nurse then conducts the departing patient to the office, where the account is settled.



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The Determination of the Water Balance*

By FRANCES E. ROGERS

Metabolism Dietitian, Royal Victoria Hospital, Montreal, Que.

IN 1837 the first reference to the importance of the determination of the water balance was made by Celsus.¹ In a discussion of dropsy he says: "Nor is it improper to measure both the drink and the urine for if more fluid is excreted than is taken so at length there is hope of good health."

Since that time many, through the last century, have published articles on water balance, but not until comparatively recent years have comprehensive studies of water metabolism been undertaken.

It was in one of these that Rubner² explained that water constituted more than 70 per cent of protoplasm, which is the structural basis of organic life. He also noted the fact that during starvation an animal can lose practically all its glycogen and fat, half of its body protein and approximately 40 per cent of its body weight, and still live. Whereas the loss of 10 per cent of the water content of the body results in serious disorders, and when the loss of 20 to 22 per cent is reached, death ensues.

Within recent years studies on water balance have been carried out by an increasing number of investigators, among them being Benedict, Carpenter, DuBois, Soderstrom and Rowntree. Rowntree³ in his article on "The Water Balance of the Body," defines water balance as the daily relation between the total amount of water entering the organism through the ingestion of liquids and food, and the total output of water lost from the body by way of the kidneys, bowels, lungs and skin. In the intake must be included the water of oxidation.

In determining the true water balance of an individual, much more is involved than the subject might suggest. The fact that as a rule a record is taken only of the fluids ingested and of the fluids excreted in the urine, makes the studies of water balance very inaccurate, whereas in determining the true fluid intake one should consider the water derived from the following sources:

Water Intake

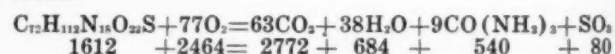
1. Water from food, for example, 100 grams of orange contains approximately 88 grams of water.⁴

2. Fluid intake (from tea, coffee, water).

3. Water of oxidation:⁵ (a) the oxidation of 100 grams of protein yields 41 grams of water; (b) the oxidation of 100 grams of fat yields 118 grams of water; (c) the oxidation of 100 grams of starch yields 55 grams of water.

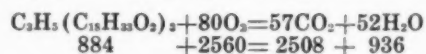
It may be shown by the following equations how protein, fat and carbohydrate yield water:

Protein:



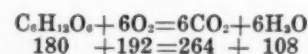
Therefore it may be seen from the above that since 1612 grams of protein yield 684 grams of water, that 100 grams of protein would yield 42 grams of water.

Fat:



Therefore, since 884 grams of olein yield 936 grams of water, 100 grams of olein would yield 106 grams of water. As the composition of human fat consists of the combination of palmitin, olein and stearin, this factor would influence the amount of water produced per 100 grams of fat.

Glucose:



Therefore, since 180 grams of glucose yield 108 grams of water, 100 grams of glucose would yield 60 grams of water. The amount of water derived from the oxidation of carbohydrates depends upon the glucose yields of that carbohydrate. The quantity of water that the body derives from solid food is more than is generally recognized. This may amount to one litre per day.

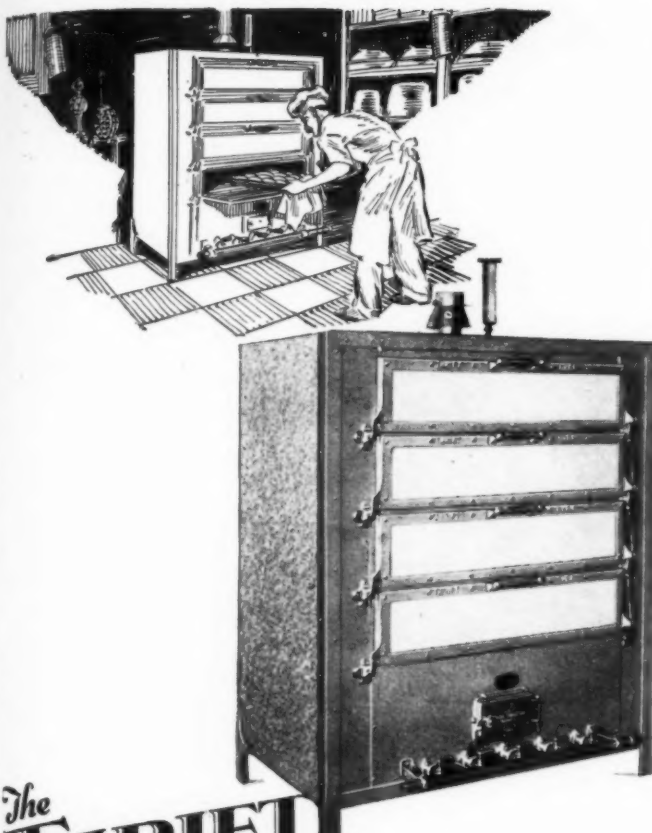
A fairly accurate estimation of the water content of food may be obtained by using reliable tables of food analysis.⁴ As the same article of food varies in quality and in other ways, the only accurate means to employ would be to have aliquot portions of the same foods that are eaten, analyzed daily in the laboratory.

The average normal water of oxidation amounts to approximately 300 to 400 grams daily, in man the amount varying with the type of diet. A striking example of the importance of the water of oxidation in animals is shown during the period of hibernation. The bear, well

*From the University Clinic, The Royal Victoria Hospital, Montreal, Que.

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padding with fat, enters his close quarters for his long sleep. Metabolism then proceeds at an extremely low level, heat being largely produced from fat, which in its oxidation yields relatively large quantities of water. Another instance of the vital importance of the water of oxidation is shown in the ability of the camel to travel for long distances without fluid, utilizing the water that comes from the oxidation of the fat in his hump.

Water Output

Channels through which fluid is lost to the body are: urine; the skin and lungs; the feces.

The volume of urine may be determined by making a careful collection of the total urine output during each period of twenty-four hours. The average amount of urine is approximately 1500 to 2000 cc. daily, the amount varying directly with the amount of fluid ingested.

In accounting for the water output through the skin and lungs, there are several factors that exert a varying influence. Of these exercise and climate are the most important. Rowntree¹ has well explained the influence that these factors exert upon water excretion. Individuals who lose an excessive amount of water through the sweat glands, excrete less urine, and those who excrete less through the sweat glands excrete more urine. Thus the total fluid output remains fairly constant. Under average conditions the amount lost by these channels has been found to be approximately 700 grams per day.²

Under ordinary conditions the water in the feces rarely amounts to more than 200 cc. per day. Usually it varies between 60 to 150 cc. On a vegetarian diet it may reach 300 cc. a day.³

From the above it can be seen that the usual clinical records of determining the fluid intake as gross fluid, and the fluid output as the urine volume, are far from accurate. An exact knowledge of the factors involved in fluid intake and output is necessary for an exact estimation. On account of the difficulties of obtaining sufficient data to derive a true water balance in clinical observation over short periods of time, the change in body weight is frequently employed. That such fluctuations of body weight are largely due to a change in the water content of the tissues may be seen from the calculations upon the following case.

Coordination of the Metabolism With Change in Body Weight and Water Balance

The following calculation showing the influence that water balance played in the change of body weight, was carried out upon an obese woman, weighing 248 pounds upon entering the hospital.

For six days after admission she was given a diet of one-half her predicted basal calories. For the next two days the diet was reduced to 500 calories per day, containing 40 grams of protein. During this period the woman continually lost weight.

During the next seventeen consecutive days, the period covered by the experiment, the daily food intake consisted of protein, 40 grams; fat, 5 grams and carbohydrates, 10 grams. Sodium chloride, 3 grams, and 100 to 300 grams of thrice boiled vegetables, with three bran wafers (of no food value), were also given.

In making this calculation the following facts were available: The patient was weighed every day. The gross fluid intake and urine volume were known. The exact composition of the diet was known. The nitrogen of the urine was determined each day. The basal metabolic rate was taken approximately every third day. The water content of the thrice boiled vegetables was known,

through analysis, to be approximately 99 per cent.

In addition to the above facts it was necessary to make assumptions. The protein oxidized was calculated from the urinary nitrogen which was known, plus 10 per cent for stool nitrogen. Due to the preliminary low diet it was assumed that the tissue glycogen was largely exhausted. Thus the sole source of carbohydrate calories would be the food. The fat oxidized was determined by the difference between the total heat produced and the protein and carbohydrate calories. This total metabolism was assumed to be 20 per cent over the determined basal heat production. This was considered to be fair since the patient's activities were limited.

The water lost through the skin and lungs was taken as 800 cc. daily, based on the fact that the average-sized normal individual loses approximately 700 cc. per day⁴, the extra cc. being allowed on account of her increased surface area. The water lost in the feces was assumed to be approximately 125 grams daily, based on the fact that 60 to 150 cc. is lost on the average⁵, and that her diet was mainly vegetarian.

Theory of Calculation of Water of Oxidation

In order to estimate the water of oxidation it is necessary first to find the amount of protein, fat and carbohydrate oxidized by the individual during the given period of time.

The amount of protein oxidized is obtained by multiplying the total nitrogen excreted by 6.25. Forty-one per cent of this amount equals the water of oxidation from the protein.

The amount of water from the oxidation of carbohydrate is obtained by taking 55 per cent of the carbohydrate oxidized.

The amount of water from the oxidation of fat is obtained by first finding the number of grams of fat oxidized, and then taking 118 per cent of that amount. The total water of oxidation would be the sum total of the water of oxidation from the three sources.

Calculation (17 Days)

A. Water Intake

1. Water from food ⁶	5237. cc.
2. 99 per cent water in 3800 gms. thrice boiled vegetables	3762. cc.
3. Fluid intake (tea, coffee, water	26050. cc.
4. Water of oxidation:	
(a) protein	505.9 cc.
(b) fat	3631.6 cc.
(c) carbohydrate	93.5 cc.

Total fluid intake.....39280. cc.

The actual calculation of the water of oxidation was as follows:

a Protein

Urinary Nitrogen	179.34 gms.
Stool Nitrogen (10 per cent).	17.93 gms.
	197.27 gms.

Grams protein oxidized:	
197.27 × 6.25.....	1232.9 gms.
Water of oxidation from protein, 41 per cent of 1232.9	505.9 cc.

b Carbohydrate

Carbohydrate oxidized	170. gms.
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The investigations of Howland and Marriott show that the therapy of acidosis resulting from food intoxications agrees closely with the general effects of the treatment of acidosis in nephritis and in diabetes.

Food Intoxicants

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Water of oxidation from carbohydrate, 55 per cent of 170	93.5 cc.
c. Fat	
To estimate amount of fat oxidized:	
Protein oxidized	1232.9 gms.
Carbohydrate oxidized	170. gms.
	<hr/>
	1402.9 gms.

Calories from protein carbohydrate:	
$1402.9 \times 4.1 =$	5751.9 cal.
Basal calories (average) + 20% =	2022.0 cal.
Heat production (17 days): $2022 \times 17 =$	34374.0 cal.
Calories from protein and carbohydrate	5751.9 cal.
Calories from fat:	
$34374.0 - 5751.9 =$	28622.1 cal.
Grams from fat oxidized:	
$28622 \div 9.3 =$	3077.6 gms.
Water of oxidation from fat:	
118 per cent of 3077.6....=	3631.6 cc.
Total water of oxidation =	<hr/>
	4231.0 cc.

B. Water Output	
1. Urine	25630. cc.
2. Skin and lungs (800 cc. per day)	13600. cc.
3. Feces 125 cc. per day.	2125. cc.
Total fluid output.....	<hr/>
	40955. cc.
C. Balance Between Intake and Output	
Total fluid output	40955. cc.
Total fluid intake	39280. cc.
Negative balance to body =	<hr/>
	1675. cc. = 1.67 kilos
(Associated with change in body weight)	
D. Water Balance Correlated With Loss of Body Weight	
Protein oxidized	1232.9 gms.
Protein intake	675.0 gms.
Protein oxidized from tissues	<hr/>
	557.9 gms. = 0.558 kilos
Fat oxidized	3077.6 gms.
Fat intake	85.0 gms.
Fat oxidized from body tissues	<hr/>
	2992.6 gms. = 2.990 kilos
Total oxidized from body tissue.....	<hr/>
	3.548 kilos
Loss in fluid weight	<hr/>
	1.670 kilos
Total loss of weight (calculated)...	<hr/>
	5.218 kilos
Total loss of weight (actual)	<hr/>
	5.1 kilos
Difference.....	<hr/>
	0.118 kilos

From the above calculations it can be seen that over a seventeen-day period, there was little discrepancy between

the calculated and the actual loss of body weight. The actual difference was only 0.118 kilos. After accounting for all loss of body tissue the remaining balance checked fairly closely with the negative fluid balance.

For short period observations, when little tissue loss is anticipated, it will be seen that fluid balance can best be told through fluctuations in body weight. Due to the several factors involved in an accurate fluid balance determination, it would thus appear wisest to judge such balance largely by shifts in body weight.

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Liver Diets a Treatment for Pernicious Anemia

The Minot-Murphy diet, which prescribes large quantities of liver, and other visceral organs, combined with proper proportions of other foods containing iron, obtains gratifying results in the treatment of pernicious anemia, says Dorothy Layton, chief dietitian, St. Boniface Hospital, St. Boniface, Manitoba, in an article in the *Canadian Nurse*.

The nurse's problems in trying to keep the patient contented with a liver diet are increased by the fact that many people, especially invalids, do not care for liver. It is fortunate therefore, that when a patient does take liver in his diet for a while, there is generally a gradual increase in appetite for other foods.

In England and France liver is a popular food, and many recipes have been found for its preparation, other than frying. If the meat is prepared in a variety of ways, the patient is not so apt to feel a distaste for that kind of diet.

Liver can be made into tempting dishes, and following are some recipes favored in Europe.

Liver pulp: Put raw liver through a meat grinder several times, using the smallest attachment. Add enough cold water to make it the consistency of heavy cream; strain, using a coarse sieve or potato ricer. Serve with orange juice. (This preparation is generally given to patients who are just starting the liver diet.)

Cream of liver soup: One half cup of scraped liver, 2 cups milk, 1 teaspoonful flour, 1 teaspoonful butter, seasoning. Melt the butter, add flour, add milk, and seasoning; boil a few seconds; add liver, and serve on toast.

Mock duck: Stuff a fresh calf's liver with dressing; put in a pan; cover with strips of bacon fat and allow to bake for two hours, basting frequently.

Spanish liver: 2 teaspoonfuls rice, 5 ounces liver, 3 cloves, one-half cup tomato, 2 teaspoonfuls onion, 3 red peppers, 3 peppercorns, seasoning and bay leaf. Boil liver with spices until tender, dice; boil rice; combine all ingredients and mix with a little soup stock; simmer until thick and serve.

Stuffed baked onion: 1 large onion, 5 ounces liver, 2 teaspoonfuls celery, salt, water. Boil the liver (save the stock for other dishes); grind liver and celery; scoop out center of onion and fill with liver mixture; bake until tender. (Carrots, tomatoes, potatoes or other vegetables may be used instead of onions, if desired.)



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OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 151 Fifth Avenue, New York
A. K. HAYWOOD M.D., Superintendent, Montreal General Hospital, Montreal, Que

Cornell Clinic—A Going Concern*

NEARLY six years have elapsed since the experiment of conducting a pay clinic under the auspices of the Cornell University Medical College, New York, was undertaken.

This clinic has been found feasible and judging from continuous growth, has become well established. There is evidently a demand for such services as it was intended to furnish. It has apparently won the confidence of its patients, who not only come back but send their friends. This increase has occurred with the least amount of publicity. Publicity, in fact, has been unnecessary to bring in patients. The demands have been far beyond the physical capacity of the present building. It has been impossible to take care of all those who wanted to be admitted, even within the strictly limited economic groups eligible for the clinic.

Up to July 1, 1927, a total of 108,318 patients had been admitted.¹ Some of these have been reregistered or reinstated at different times. These patients made a total of 671,425 visits during the entire period, or an average of 6.2 visits for each patient. These figures require this explanation: visits to different departments are counted separately, even if made on the same day; or some of the visits might have been made at widely separated intervals, for different conditions.

Admissions Increase

A more accurate impression will be gained by referring to Table I, giving number of new admissions, patients reregistered, total individuals and number of visits during each of the last three years. It will be noted that there is a progressive increase of both new admissions and old patients reregistered. The ratio of old patients to new is about 1 to 2.65, while there have been nearly five visits per individual patient treated. The total number of visits for three years was 370,222. This might indicate that patients were well enough satisfied to come again and to tell others about it. This is only presumptive evidence but it means more after six years than at the beginning, when the scheme was still new. Time has not brought disappointment.

More than 4,000 physicians residing within the metropolitan area have sent approximately 15,000 patients for diagnosis. A number of physicians have sent more than 100 and one has sent more than 400. These are not connected with the college teaching staff or the staff of the clinic. They are outside practitioners. These figures

would help to dispel earlier fears and dire forebodings that the clinic would be a menace to the private physician, especially the general practitioner, who can usually charge only a moderate fee. These 4,000 practitioners, living within a radius of twenty-five miles from the center of the city, and representing probably about 12,000 registered physicians of New York, New Jersey and Connecticut, must be satisfied of two things—that their patients are given adequate care and that the clinic will protect their professional interests. If these conclusions are unwarranted, would they continue to use the clinic in this way and in this measure?

TABLE I

	(1)	(2)	(3)	(4)	(5)	(6)
DURING YEAR ENDING	NUMBER OF NEW PATIENTS	NUMBER OF OLD PATIENTS REINSTATED	TOTAL INDIVIDUALS CARED FOR	RATIO OF NEW PATIENTS TO OLD	TOTAL VISITS TO CLINIC	NUMBER OF VISITS PER INDIVIDUAL
June 30, 1925..	17,370	5,817	23,187	2.98	118,244	5.00
June 30, 1926..	17,414	6,828	24,242	2.55	118,870	4.90
June 30, 1927..	19,161	7,677	26,838	2.49	133,108	4.99
Total, 3 years..	53,945	.....	.....	.....	370,222	.....

Note: As patients may be reinstated in successive years the same patient might be included twice in column three. Therefore the total of this column might not be correct and is omitted. The same factor would of course affect the total number of individuals cared for in column four and total of this column is omitted for this reason. The return of old patients as shown in column five is of special significance.

From the financial point of view, the clinic is beginning to fulfill the hope of its proponents. The operations for the first two years showed a deficit of \$72,000. This was met jointly by the college and the Committee on Dispensary Development. This committee also met a cost of \$32,500 for new equipment bought at the time of the reorganization. It was then found expedient to increase the fee from \$1 to \$1.50 per visit.

During subsequent years, there has been an average progressive gain in operating revenue as compared with operating disbursements. Both have grown larger with the expansion of the work. During the fiscal year ending June 30, 1926, there was a little gain of revenue over operating expenses, but not enough to pay for new equipment bought during the current year, or for any depreciation of old equipment. This deficit was met by the college out of its own funds.

*Condensed from the fifth annual report of the Clinic of the Cornell University Medical College, New York.

¹ Up to Nov. 1, 1927, 113,507 patients had been registered.

Peach Rice Pudding

Fill dessert or sherbet dishes half full of moist rice pudding. On the top place a Libby Peach half, cut side upward. Over the pudding pour raspberry sauce

For the Soft Tray

Libby's Peaches, put through a sieve and added to a soft custard make a pleasing dessert for the Soft Tray

A Popular Salad

On a bed of crisp lettuce, place a Libby Peach half. Around the Peach arrange five Libby's Royal Anne Cherries and three small balls of cream cheese. Top with mayonnaise, sprinkled with paprika

For breakfast in the Children's Ward

Breakfast cereal is much more popular in the children's ward when served with Libby's Peaches and cream



To break the *monotony* of the convalescence diet

Attempting peach dessert your patients will enjoy

It's a time when dietary problems are particularly difficult—convalescence. For the patient must eat, to regain his strength, yet appetites are never more willful and uncertain.

To tempt such finicky, convalescence appetites many dietitians recommend the use of peaches. Only very rarely does a peach come back on the tray—especially when it is served in a dainty new dish like the dessert pictured above.

That such a dessert may make the strongest appeal in flavor and appearance, many large hospitals are careful always to order Libby's California Peaches. They know these peaches can

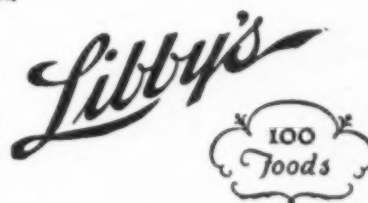
be depended upon for big, golden halves of uniform size, that have all the enticing fresh fruit flavor. For Libby's Peaches are sun-ripened on the trees and packed fresh for you in model kitchens built right at the orchards' edge.

In the same way all of Libby's 100 Foods are packed right where they grow at their best. From Delaware to Hawaii, in the garden spots of the world, stand more than 50 Libby kitchens. In these model kitchens, under the supervision of master chefs, the world's choice foods are packed for you, fresh and full of flavor.

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Mince Meat
Boneless Chicken

During the fiscal year, ending June 30, 1927, the average cost per visit was \$2.29 and the income per visit \$2.41. The clinic was able to meet operating expenses of \$305,000, pay for all new equipment bought during the same year and leave a small fund out of which to repay the college for some of the former equipment furnished. So far the clinic has not paid the college any rental for approximately 16,000 square feet occupied. The college has also paid, out of its own general funds exclusively, all grants for research, amounting to \$3,834 up to June 30, 1927. A sum of \$12,000 was made available July 1, for the current year. The college also meets out of its own funds the entire budget of the departments of pathology, bacteriology, physiology, clinical pathology and the medical library, which are used extensively by the clinic. The department of clinical pathology, especially, does a great part of the laboratory work for the clinic, and supervises the work of the two branch laboratories maintained in the clinic itself.

Clinic Is a Teaching Institution

The question therefore whether the clinic is self-supporting is largely one of accounting. We cannot say truthfully that we are giving medical care at cost unless we know what to include under the term "cost" and define what is meant by "medical care." As a private enterprise, the clinic could not long survive on the basis of present moderate fees. Nor could the clinic hope to retain the right kind of medical staff at the existing rate of compensation, if it were not a teaching medical institution of preëminent standing, offering opportunities for scientific development, study and research.

The thought has been expressed on numerous occasions, especially by the dean of the college, that the clinic should be developed somewhat as a laboratory for the practical application of preventive principles of medicine. The first step in this direction was the establishment of periodic health examinations as a subdepartment of medicine. Beginning in 1922, this service has shown satisfactory growth. Some of its patients have come, simply through general knowledge and personal desire, to have such complete physical examinations. These individual applicants constitute the greater part of the year around case load. At certain seasons there have been special groups, personnel of agencies engaged in health work themselves or personnel of minor corporations. During the last two years all the students of the college have been given periodic health examinations.

In 1926, the director of the clinic was made a member of the faculty in the department of public health and preventive medicine, and was delegated by the head of that department to take over part of the lectures during the third year. At the same time the subdepartment of periodic health examinations was detached from the department of medicine and placed directly under the supervision of the director. The purpose of this change was to correlate preventive medicine more closely with clinical medicine, by providing a means of practically applying the principles of prevention.

The question has been asked by innumerable inquirers, "Is there any obstacle or particular difficulty in using pay clinic patients for teaching students in the college?" It may be stated unequivocally that the pay clinic patient can be used for teaching and demonstration purposes as readily as the patient of the free clinic or out-patient department. It is taken for granted that ordinary tact and courtesy will be employed in asking patients to present themselves at a demonstration clinic before a whole class of students, and that a little ingenuity and

imagination will be exercised in assigning undergraduate students as clinical clerks or examiners on first admission or revisit consultations. On the whole, it may be stated of the pay clinic patient, that superior natural intelligence and a better spirit of cooperation, make him more willing to have his case studied for teaching purposes or in connection with teaching. He readily understands that where a case is to be presented to the "professor of the department" before a body of students, where errors and shortcomings will be shown up, his case will be given fullest consideration. He is also alive to the advantage of having the consultant opinion of the head of the department, and his advice as to the management of the case.

The above reaction is not based on personal impression alone, but was formulated after careful study and analysis by the chiefs and staff of all the clinic departments. This study was undertaken during the past year, initiated by the clinic chiefs themselves, introduced by means of questionnaires, and subjected to full discussion at several successive meetings as part of the regular proceedings. The few complaints made by patients in connection with teaching were justified, and were based upon special conditions that needed adjustment. Similar circumstances in a free clinic would probably have given rise to a much larger number of complaints and to more serious mass reaction.

When students are assigned to practical courses in the clinic they usually work either individually or in teams of two, under the supervision of one of the regular staff men. Efforts are made to have students spend at least two months of consecutive work in each course. Examinations of patients are conducted under conditions simulating as closely as possible those pertaining to private offices. The regular staff member in reviewing the findings of the student, is expected to do this in the manner of a private consultant, especially as to his manner of addressing the student or discussing the case in the presence of the patient. Such an attitude of courtesy and respect will naturally help in making the pay clinic patient more willing to serve as teaching material.

Demonstration Clinics Held

This advantageous plan of individual practical instruction is one of the outcomes of the existing system, while it is also one of the expedients that have come as a result of physical limitations. Demonstrations to larger sections are difficult because of the absence of rooms large enough for conferences or seminars. The subdivision of space into individual private booths or cubicles has therefore made the division of students into small teams expedient. This has not been without some advantage, as may be inferred. However, some of the clinic material is also used for class demonstrations or clinical lectures in connection with the fundamental clinical courses. These demonstration clinics are held in one of the lecture rooms of the college proper, patients having been assigned or "invited" from the respective departments of the clinic.

One of the most important features of the pay clinic scheme is the appointment system with control of intake. From the point of view of teaching this offers the advantage, that only a limited quota of patients is assigned to each physician during a clinic session. This offers better opportunity and gives greater incentive to prepare a case carefully, to discover its interesting features and to obtain full information as to environmental conditions through the social service or clinic executive division. The result is better clinical work. At the same time the handling of a patient under such conditions of individual

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consideration, serves to show the student what he would be expected to do under similar conditions in private practice.

It is hard to conceive of anything more detrimental to the student than obtaining his ideas as to the care and handling of patients through examples offered by old type dispensaries, with their system of mass treatment. It is not surprising therefore that the hospital ward came to be emphasized as the most advantageous means of teaching the student the practice of medicine. Here there was a limit of intake, a limit set by the number of beds. There was time to study the case carefully, to keep the patient under observation and correlate different points of diagnostic evidence. But as a consequence the student came to recognize only terminal or at least more advanced stages of conditions that were totally disabling. He was kept in comparative ignorance of the milder, earlier beginnings of pathological changes, which occur before the development of more serious stages, and when moreover the condition was more amenable to treatment. Such contact with terminal conditions, might easily suggest the futility of therapeutic measures and invite therapeutic nihilism.

Student Has Valuable Experience

With the better development of out-patient service, the adoption of better record and filing systems, and proper control of intake, better opportunity is offered to show the student conditions he will meet with in private practice and train him in formulating a plan of treatment in such conditions, which will develop more fully the possibilities of both curative and preventive medicine.

As a corollary to the above it may be stated that the very features that bring about these advantages, predicate a somewhat higher cost of operation. Punctuality and regularity of attendance of medical staff are necessary to insure successful application of the appointment system and controlled intake. Holding the medical staff to proper performance of duty would postulate their being paid. With a paid staff it is a matter of economic administration to relieve them of routine nonprofessional details. All of these problems can be solved more readily in the pay clinic, planned to furnish medical service at cost or as nearly at cost as possible.

One of the disadvantages that has been mentioned in connection with controlled intake is the possibility that with a limited total number of patients there might be difficulty in selecting cases to illustrate demonstration clinics, covering a systematized course. It is a question whether mere total number of cases would affect opportunity for selection. Rare and unusual conditions might be found more readily if patients came from different social strata, bringing into play such factors as vocation, race, environment and other hygienic factors. Interesting conditions might be discovered more readily among a hospital or in-patient group, where advanced or complicated conditions would be more apt to be sifted out.

Indirectly related to the question of teaching in a pay clinic, is the question whether a pay clinic can be operated successfully in connection with a teaching hospital, as its out-patient department. Where ward patients are cared for and treated without charge, provision must be made for their care and treatment as out-patients, either before or after their hospitalization.

To a limited extent this is being done at the present moment in a few institutions. Certain classes of patients are paying fees for examination and diagnostic service, using the same admission, registration and examination facilities as free patients. Except in the private group

clinics, the patients paying more than nominal fees usually represent a much smaller proportion. But there is a growing tendency through the country for patients to pay for medical service. There has been an increase in the so-called semiprivate class. For a teaching institution it is of no advantage to increase its volume of material beyond a certain optimum saturation point. If a balanced load, properly cared for clinically, can pay the cost of operation, it appears mutually advantageous to the institution and the community, taking into consideration also the local practicing physician in that community.

The Value of the Intern to the Hospital

"Success in the practice of medicine depends upon knowledge made usable by the personality of the practitioner," says Dr. William J. Carrington, chairman of the intern committee, Atlantic City Hospital, Atlantic City, N. J., in a paper written for the *Journal of the Medical Society of New Jersey*. Personality is the reflection of character; medical personality, that reflection of character which commands the respect, confidence and obedience of the sick, and according to Dr. Carrington, "The job of the medical student during his internship is to develop his medical personality."

The intern must first learn to be accurate and truthful in making reports; he must willingly acknowledge his mistakes; his sincerity and interest in his work must be outstanding; he must be loyal to his hospital and its chiefs; he must develop self-confidence but avoid overconfidence; he must be cheerful but always dignified; he should develop a personal note in his conversation, in order to penetrate the barriers of strangeness to his patients, and in conversing with medical men the intern should command an easy flow of technical language.

How, it may be asked, does all this relate to the intern's value to the hospital? According to Dr. Carrington, the intern has ten times as many contacts with the patients in the hospital as any other member of the staff. This being true, the intern who can meet the above qualifications stands a greater chance of favorably impressing the patients and rendering good service to the hospital than one who lacks these characteristics.

Are Mental Patients Always Mental?

The past few years have brought about great changes in the handling of mental cases. Years ago a mental case was considered mental, and physical deformities and infections were not considered at all in the handling of such a case. Time and experience have brought about the great changes which we now note in the handling of a mental case. Observation and the recording on paper of certain reactions has ceased to be the method of diagnosis. Today a mental patient is given a thorough physical examination with the object of determining, if possible, the cause of the mental disturbance.

Statistics taken from an article in a recent issue of the *Atlantic Medical Journal* show us that approximately 15 to 20 per cent of the mental cases are so disturbed that cooperation in a mental examination is impossible. If in such a case as this a physical disease is present, it may have time to run its course before the patient recovers sufficiently from his abnormal mental state to realize its presence and take steps to cure it.

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Monolithic Furnace Lining Makes Good

By BROTHER ALPHONSUS

Chief Engineer, Alexian Brothers Hospital, Chicago

MUCH has been written and said concerning furnace linings, but a comparative test made during the last nineteen months in our boiler house at the Alexian Brothers Hospital, Chicago, has convinced us that a high grade monolithic furnace lining is capable of giving remarkable service even under operating conditions that have caused other types of lining to fail.

In July, 1926, we installed the lining made from a manufactured plastic material in one of our two coal-fired boiler furnaces, and just a short time ago a careful inspection of this lining showed it to be in such good, undamaged condition that it is apparently ready for another nineteen months' run without trouble.

As we had not been satisfied with other linings used in these furnaces, the success of the plastic material was exceptionally gratifying. This lining has been given extremely hard service, because the unsatisfactory results from the lining of the companion furnace have forced us to use this one more than 80 per cent of the time. No patching or repairing of any kind have been necessary, although the lining has been carefully inspected each time it was off the line.

Originally the two furnaces—one installed four years ago and the other three years ago—were lined with brick, but the continual expansion and contraction, due in great measure to the sudden peak power demands of hospital service, soon loosened the mortar between the bricks and developed bad cracks. This made us investigate the monolithic furnace lining, which is installed in plastic form and vitrified under the heat of the furnace to form a one-piece lining.

Other Materials Unsatisfactory

We did not know a great deal about the different grades of furnace lining, and the older one of the furnaces was first lined with material that either did not have the correct ingredients for our work or was poorly installed. Like many others we had the idea that almost any kind of refractory material would be all right, and that no particular care was necessary in installing it. However, a city ordinance prohibited us from putting the material in ourselves, but we did dry out the lining after it had been pronounced ready by the installers. We were careful

to dry slowly and maintained a small fire for twenty-four hours to be certain of the drying. But despite all the care and high hopes, bad cracks appeared in this lining within two months. Attempts were made to cement and patch it, but the results almost discouraged us.

Finally we decided to try a plastic monolithic lining, produced by a manufacturer so sure of his product that he gave a written guarantee of one year's satisfactory service. We were not hopeful, owing to our experiences with the other linings, and were beginning to think our particular kind of service was too hard for any lining to give satisfaction for any length of time. Our 205-horsepower boilers usually operated below their rating, but there are many sudden demands for steam, which throw a heavy burden on the boiler for short periods and produce great strains on the furnace lining.

Careful Installation Is Important

Our hospital has a steam-consuming laundry large enough for a 400-bed institution and for all the attendants, nurses, doctors, and others required for such a place. Large quantities of steam are also used for keeping food hot, for sterilizing, for the operating rooms, for heat and for the generation of electricity. With these various factors, one never knows when there will be some activity that will make the load jump suddenly from around 4,500 pounds to 7,000 pounds of steam per hour. Since it cannot be determined in advance when these peaks are liable to come, we have an automatically controlled balanced draft for each boiler.

When the demand comes the draft is increased quickly, intensifying the fire, and of course the furnace walls are rapidly heated to a high degree. The load usually drops off as fast as it comes, the draft is reduced, and the fire cooled quickly so as not to waste fuel. This rapid heating of the walls and then the quick reduction of their temperature is strenuous testing for any lining material, as we have discovered.

However, one company stated that their plastic material would stand it, so we let them install their kind of lining. Since we believed that poor workmanship in installing may have caused the trouble with the lining in the other furnace, we were particularly careful to see that this one

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was properly installed. From our own experience we knew the material must be installed solidly, and this lining was pounded in compactly with a mallet. The outer surfaces were shaved to permit moisture in the plastic material to escape, and consequently to prevent spalling from entrapped steam. A substantial eight-inch wall was built, although the entire work was done in a very short time. As with the other lining, we did the drying ourselves. A low fire was maintained for twenty-four hours, which is twice as long as the manufacturer recommended, but we wanted to make sure we should not be blamed for improper drying.

After the drying of the plastic lining had been accomplished, a regular fire was started under the boiler. This was increased gradually, as is our custom, until full load was obtained. It has been our experience that it pays to exercise care in putting a boiler back on the line and in taking one off the line. Too rapid heating or cooling will naturally cause bad strains in the setting, and that is why we claim some credit, along with the manufacturer, for the success of this installation.

For it did make good. It has been fired continuously, twenty-four hours a day, for periods as long as sixty days at a stretch, and yet there has been no need for repair. An unnecessary attempt was made to close the small crack that naturally developed between the monolithic lining and the fire brick of the front wall. Some cementing material was obtained from the manufacturer and the crack was filled. However, this division between the plastic and the brick does not need to be closed, as we learned. One small hole was left in one side wall for balanced draft purposes, but apart from that there is no hole even today in this lining. No plastic material was placed on the front wall, for it was thought that the old lining could withstand the lower temperatures and lack of flame action there. But even on the front wall the lining has cracked and broken away.

Lining Withstands Severe Tests

Because of our own negligence we may be obliged to replace a small part of the lining—about four inches at the bottom of the walls. Coals from the fire have been permitted to roll over to the side and lie along the walls. This is bad practice from a combustion standpoint and should not have been permitted. The other parts of the lining have withstood the hardest kind of firing, and with this boiler carrying nearly all the work. Using slice bars and rods on the fire, and prodding and scraping the sides have not caused any damage to the monolithic work. Even slag has adhered to the lining and been pried off without causing damage to the vitrified surfaces.

These walls have received harder service than the other furnace walls, because of changes made in the draft and the grade of coal used. Formerly a green coal was used, which required excessive draft to make it burn properly. Naturally the strong draft carried the flame back over the fire wall, and a lot of heat was carried on up the stack. This year we are using a better grade of Illinois coal and using a lower draft with it. This gives greater efficiency but also increases the forces working against the lining, because the fire is much hotter. The recent inspection has shown, however, that the lining is standing up well under the more severe action. In fact the first inspection made over a year ago showed that the lining had vitrified well at the first heating, and later heatings have served to make the vitrification better and better.

The success of this one lining led us to try and patch the other furnace with this material. Part of the worst

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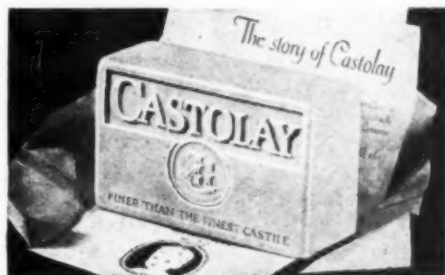
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cracked wall was torn out, and the plastic material pounded in and shaved off to make a patch about four feet in diameter. This patch has also stood up well, although the other material around it has disintegrated and worn away. On the opposite wall of this furnace the old lining has worn away, until a distinct hollow several inches in depth can be noticed clear across the face of the wall. This wearing away has left only a few inches of the material, and the entire lining will have to be replaced in a short time. Sometimes the lining of this other furnace has actually become molten and run when it was subjected to a hot fire, so part of this material has evidently melted away.

New Lining Saves Money

Figured roughly the high grade monolithic furnace lining saved us about fifty dollars the first year because it required no patching or repairing of any kind. Before summer comes it will save us another fifty dollars, and when we have to replace the other worn lining, this installation will save us the entire cost of a new lining. The cracks that have developed in the older furnace have caused disruption of the boiler setting, and that will demand additional expenditure to put it in shape again. The biggest savings have been in the better combustion and greater efficiency of the boiler, but just what this amounts to is rather difficult to say. However, lumping all savings, we have found the installation of a good grade of plastic monolithic furnace lining has saved at least twice its cost.

Perhaps in the old days when little attention was paid to combustion, and the coal was just thrown in to burn as best it could, a good furnace lining was not so important. But in modern boiler practice a good, dependable furnace lining seems to be the first essential of efficient operation. There is no economy in spending money for CO₂ instruments, thermometers, and balanced draft unless one can be sure of absolute control, by having a real furnace lining. In our own case, with the two furnaces side by side, having the same demands to meet, the comparison has shown strikingly the economy and good practice of a high grade monolithic furnace lining.

Electric Arc Welder Replaces Noisy Riveter

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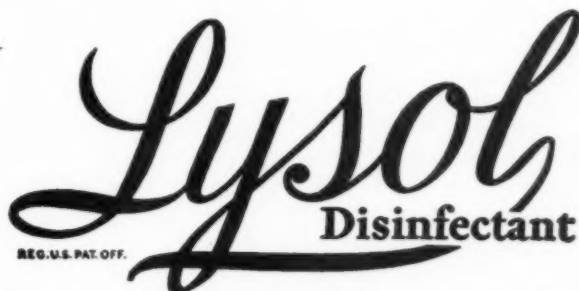
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Junket actually improves the most nearly perfect food we have—good, rich milk. It makes milk far more palatable, really tempting to many who think they cannot drink milk. In addition, the active principle of Junket—rennin—in transforming milk into custard-like junket, actually performs the first step necessary for its perfect assimilation.

Junket is one of the few foods which are suitable as a family dessert, as a definite, health-building addition to the invalid's diet, and at the same time, an almost perfect food for the small child.

You will find Junket Tablets also of great value in the preparation of such infant's foods as Whey and Eiweiss Milk. Standard diets, formulae, and scientific basis for use of Junket are given in our authoritative booklet, "Junket in Dietetics"—free on request.

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MAKES DELICIOUS MILK FOODS

Junket Tablets, not sweetened or flavored, in packages of 100; Flavored Junket, sweetened, in pound cans, specially prepared for hospital use. Specify flavors desired:

Vanilla
Chocolate
Lemon

Orange
Raspberry
Coffee

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Junket and Milk
Partners in Health

struction of a number of modern skyscrapers. The manufacturers of the welder have shown their faith in the instrument by using it in the construction of one of their own buildings, in which 989 tons of steel were welded together.

Cabinets with Adjustable Shelves That Save Space

Cabinets made of furniture steel and claimed to be sanitary, fire-resistant, vermin-proof and rat-proof have recently been introduced. These cabinets are strongly built with nickel-plated door handles that cannot be removed from the outside.

In the manufacture of these cabinets it is interesting to note that the steel is bathed in acid, prior to being assembled, and is then finished with a heavy coat of gray



enamel or other solid colors. It is also possible to produce these cabinets in any wood grain specified, to match other furniture.

The shelves are adjustable on one-inch centers, so that waste space is eliminated by adjusting the openings to the height desired. It is stated that the cabinets are almost air-tight and are wholly dust-proof.

Maintaining Kitchen Equipment

By J. E. DAUGHERTY, M.D.

Executive Director, Jewish Hospital, Brooklyn, N. Y.

Equipment that will stand up under stress of wear and hard usage seems to be the first essential in the furnishing of a kitchen.

Institutions handicapped by inferior quality of utensils, inadequate pantry shelving and antiquated refrigerators can materially reduce upkeep and overhead by ruthlessly junking such material and refurnishing with proper equipment.

This hospital has gone through the throes of such an experience. Tinned utensils have been replaced with aluminum; roasting pans are now of monel metal; the old wooden ice box was thrown out bodily and a refrigerating room built of insulated concrete; a pantry was added with steel shelving, and steel lockers were provided for the clothes of the personnel; gas ranges were substituted for coal ones and a small but complete bakery, equipped with oven, mixing table and those small affairs that may be called tools, for the comfort of the baker.

A Photograph is a Record

Beyond the impersonal, unbiased accuracy of a photograph lies its unequalled value as a record—a permanent record.

There are cases, daily, in hospitals, clinics, and even in private practices that, because of scientific interest or legal protection, deserve to be photographed. Many case reports are ambiguous and inaccurate without photographs to supplement the clinical data. It is for these reasons that no hospital is completely equipped which lacks adequate means for photographic records.

The Eastman Clinical Camera Outfit has been designed to meet such needs exactly. All fussy contraptions have been eliminated—just those features are incorporated which lead to making satisfactory medical photographs. The outfit, including camera, lens, shutter, lantern slide back and two floodlights, sells for \$180 at your dealer's.

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Popular in the men's ward— this satisfying dish

Salisbury Steak

1 cup cooked Cream of Wheat

1 pound ground meat
1 tsp. chopped onion

1 beaten egg
Salt and pepper

Mix Cream of Wheat, meat, onion and egg. Season with salt and pepper. Shape into balls. Brown in hot fat. Serve with tomato sauce.

FRACTURES, dislocated and broken bones rather than functional disorders are apt to prevail in the men's ward—and in consequence appetites are largely normal men's appetites. To satisfy them with dishes consistent with the patients' inactivity is often a problem for dietitian and nurse.

Salisbury Steak, for which the recipe is given above, is a dish ideal for the purpose. Though hearty, it is also digestible. That's because the cereal base is Cream of Wheat. Its simple granular form makes no undue demand upon digestive systems weakened by confinement. Its high carbohydrate content helps provide the nourishment that hastens convalescence.

Cream of Wheat, used with other ingredients, makes dishes go much farther and so keeps down the cost—an important factor in ward management. Forty generous servings in every Cream of Wheat package—at less than 1c a serving. And the package itself free from spoilage, because Cream of Wheat is triple-wrapped-and-sealed.

There's a free booklet—"50 Ways of Serving Cream of Wheat"—planned to give just such valuable suggestions as this one. Send for your copy today.



FOR THIRTY-ONE YEARS A STANDARD FOOD
ON PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

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With all these changes our pay roll for the culinary department dropped \$400 a year. Food that often spoiled because of lack of proper cooling facilities is now saved and our problem is one of cleanliness and not of equipment.

We find soda a necessary element in keeping ranges and broilers free from greasy incrustations, and this is applied in solution by brush or cloth. Coffee urns are washed in the same way and every article that comes in contact with food seems to require the same treatment. Small tools, such as putty knives, are given to the cleaners so that the utensils may be kept free from the dirt that lodges in crevices and corners.

Copper in any form is not popular, but such as we have in good condition is kept burnished by soap and water.

It is a mistaken economy to expect the kitchen force to maintain a presentable workshop and turn out a satisfactory product with tools no careful housewife would tolerate for a moment.

We know that food is all important to a convalescing patient and the memory of the final meal eaten in the hospital has a lasting effect on the mental attitude of the outgoing guest.

Perfect harmony in the dietary division insures good food, cheerfully and tastefully served.

Constant supervision is such a necessary element that it seems foolish to mention it, yet in this institution every single item of food served goes to the tray under the watchful eye of a dietitian or the stewardess. These women do not disappear as soon as a meal is served. They feel that the clean-up process is an all important ceremony in the preparation for the next meal.

New Butter Cutter Proves Efficient

A new butter cutter is rapidly gaining favor in large institutions. The machine is compact and neat in appearance. It is mounted on a cast iron base about eight inches high. Attached to this is the bed of the machine in which the accurate mechanism for forcing the butter through the wire meshing is located. At one end is the wire meshing with the guillotineline cutting attachment. On the sliding surface where the butter is placed, is the follower which advances the butter a fixed distance with each turn of the crank.

Several attractive features of the machine are: ease of operation, absolute sanitation, speed in cutting and uniform thickness. The main attraction is that the machine not only cuts, but separates the squares of butter all in one operation. This is made possible by an arrow-like attachment which follows the cutting wire. The machine may be set to cut 48, 52, 56 or 60 pieces of butter to the pound. It may also be used for cutting cheese.

Embossed Paper Napkin Is Both Attractive and Practical

A new paper napkin embossed with a damask linen finish has just been put on the market. This napkin is in many respects a refinement of much merit and should do much to popularize the paper napkin trade in this country. It is made in one size only, 14 by 14 inches, and is folded twice, making it compact and handy. The napkin seems to be substantial without being stiff and the embossing makes it attractive.



MOSAIC TILES IN HENRY FORD HOSPITAL

THE new Henry Ford Hospital in Detroit is a master-piece of hospital planning and construction. All materials were chosen with a single view to permanence and efficiency of operation. Mosaic Tiles have been used extensively.

It is in hospital installations—especially in operating and delivery rooms, lavatories, utility rooms, diet kitchens, autopsy rooms and solaria—that the unequalled economy of Mosaic Tiles is most plainly demonstrated. No other material is as well adapted to hospital sanitation. The constant use of antiseptic acids or aseptic steam will not injure or deface them. They are literally impervious to wear, and a generation of hard hospital usage will make no impression upon them.

Our art and design department will be glad to co-operate with your architect in the working out of detailed layouts in Mosaic Tiles. We shall be pleased also to arrange for estimates through a responsible tile contractor in your city.

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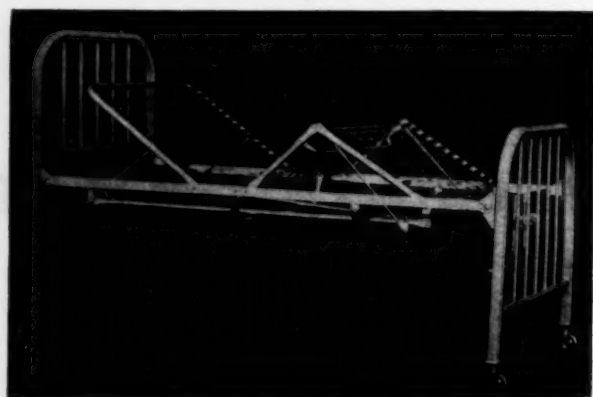
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Tubular frame posture spring is held rigid to "Artisteel" tube ends by our patented Double Anchor Corner Lock. Solid steel shafts operate thru bronze castings which reduces to a minimum the effort to adjust head and foot rests. Handles to operate shafts fold within foot end of bed when not in use—a feature nurses and attendants can well appreciate.

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ST. LOUIS, MO.
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**Genesee Hospital Buys Its Steam
From a Central Station**

By F. G. AUSTIN
Engineer, Rochester, N. Y.

Early in 1924 a hospital drive was started to raise money to be distributed among the several hospitals of the city of Rochester, N. Y., for the purpose of such expansion as the board of trustees thought expedient. The increased population had naturally taxed the hospitals to the limit, and in order that the city might take care of its sick and conduct the proper clinics, it was necessary to have more buildings.

In the summer of 1925 the Genesee Hospital began the construction of a new surgical building. This was the first step of a building program that was to continue for a considerable length of time. This inevitably increased the steam demand on the boiler plant to the extent that it was necessary either to build a new plant or to purchase steam. The steam generation plant of the hospital consisted of three, fire tube, high pressure boilers of fifty horse power each. These boilers were in fair condition, but not good enough to reset in a new building, which would be required for the increased boiler capacity.

Figures were carefully compiled by consulting engineers and it was found that a new plant would cost about \$62,700. The building committee being familiar with the merits of district heating approached an engineering firm with the thought in mind of constructing a line to the hospital, which was at a distance of 3,800 feet from the new Lawn Street steam plant just being completed. An analysis of private plant cost versus purchased steam cost was made, and the following balance sheet was prepared:

Private Plant Cost
Operating Cost

Coal, 2,120 tons @ \$6.00.....	\$12,700.00
(Includes handling coal and ashes)	
Repairs, water and maintenance.....	500.00
Labor, 1 engineer @ \$2,000, 3 Firemen @ \$1,500	6,500.00
Total	\$19,700.00
Fixed charges, interest and depreciation on investment of \$62,700.00.....	9,400.00
Total Cost	\$29,100.00

Purchased Steam Cost

25,500,000 pounds of steam.....	\$24,000.00
Interest and depreciation, 15% on \$1,000, cost of piping inside building.....	150.00
	\$24,150.00
Yearly saving in favor of purchased steam.....	\$ 4,950.00

A statement not included in the balance sheet was, that as there would be no new building required for a boiler plant, the ground space and money could be devoted to hospital buildings that would house probably an additional fifty beds. In addition to this, a careful analysis was made of the heating requirements of each room—warming cabinet, sterilizer, laundry, kitchen. The amount of steam each consumed was carefully checked and a factor determined which, multiplied by the monthly steam bill, would give the amount in dollars the steam would cost for that room or department. For example, a typical floor consisting of fourteen beds, a kitchen, linen closet, office

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PLANNED LIGHTING FOR HOSPITAL WARDS

THE HOLOPHANE "TWILITE" IS SCIENTIFICALLY DESIGNED TO GIVE
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They reduce cleaning costs

Cleaning and maintenance work will speed up after you install Dayton Safety Ladders. They eliminate fear of falling, stop one-handed working, and the running up and down for supplies.

The Dayton cannot tip or wobble, and its broad platform provides room for two men with their tools. Made of steel-braced aeroplane spruce in sizes 3 to 16 feet. Moderately priced.

Type "B" Dayton Safety Ladder, is smaller in size, popularly priced.

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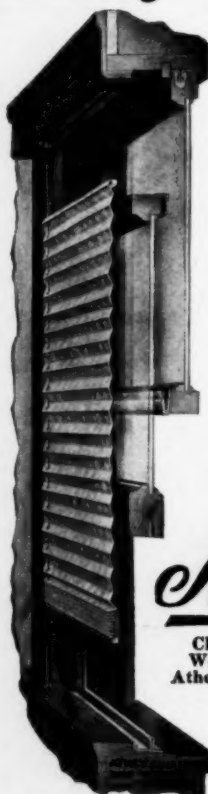
The Dayton Safety Ladder Co.
121-123 West Third St., Cincinnati, Ohio

DAYTON

Safety Ladder

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Any Window Made Perfect



Any steel or wooden window, Athey equipped, raises and lowers smoothly and easily, yet is absolutely draft-tight when closed. A large Chicago office building saved \$3500 in coal the first year. The installation of Athey Weatherstrips costs \$4900 and will last the life of the building.

When cold air enters the window, more fuel goes in the fire door

Athey Shades let in the light and eliminate the glare. Instantly adjustable to shade any part of the window.

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26 of the most modern recent skyscrapers in Detroit are equipped with Athey Shades.

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and hall would have a factor of 0.013, which, multiplied by the yearly steam cost, would give the cost of heat for that floor per year. This has been useful in determining which rooms or floors are self-supporting and which are not. The estimated steam consumption for the entire year was 25,000,000 pounds, and the hospital has kept well within that estimate.

A survey of the territory was made with the thought in mind of present and future development. It was decided to install a six-inch high pressure main for the first 1,500 feet, and a four-inch high pressure main for the remaining distance, designed for 375 pounds pressure and 100 degrees superheat, which would cost about \$80,000. At the same time, economy and speed were the two prerequisites, because it was late autumn and the hospital would need steam in a short time. The reason for the six-inch main for the first 1,500 feet was that the territory served by this main is nearest the center of the future large building district, and it could be used as a booster for an eight-inch low pressure line, which is only a few feet from where the six-inch main reduces to four-inch.

It is possible to run laterals in other districts, to cross East Avenue and parallel the eight-inch low pressure line, for a customer who desires steam all summer, because steam is on this line the entire year. This line is well placed and the business blocks along this main, together with the dwellings, quickly availed themselves of steam service and this has worked out advantageously.

Main Installed Under Sidewalk

It was decided to install the main under the sidewalk the greater part of the distance, because the streets along whose course the main was to follow were subjected to heavy traffic conditions, also they were full of electric ducts and other pipe lines, which would require a depth of from eight to twelve feet below the pavement. Placing the main under the sidewalk required a depth of only four feet, which not only hastened the work, but made it much more economical.

One of the next factors for consideration was the type of construction to be used. Two types were considered—conduit and insulation and the concrete box with sectional pipe covering. After considerable investigation and thought it was decided to use the conduit system with molded and loose filler insulation and base drain foundation. For this particular job, this system was considered the most economical, because the actual time required by a draftsman to lay out a line using conduit is less, due to the absence of detail design on different operations, which is necessary with the concrete box construction, particularly where there is a long line with offsets and street interference. This line was installed during the rainy season of late autumn, and as expected it rained nearly half the time, but even with this delay the work was completed in two months. The base drain foundation serves the double purpose of providing positive trench drainage and furnishing a two-point support for the conduit.

A general contract was let calling for conduit, extra heavy steel pipe and expansion joints. The following are the approximate costs of this installation:

Trench work and relaying pavements.....\$ 8.50 per ft.
Conduit materials installed 4.50 per ft.
Manholes, anchors and pipe work..... 8.00 per ft.

Complete, per lineal foot\$21.00

The source of steam is from the new Lawn Street plant. This plant was designed primarily for heating the down-

Nurses *easy* to "LABEL"



FREE—as many
as you want



JUST like writing on paper. That's how easy it is to write the name or formula number on the frosted panel of the Hygeia Hospital Nurser.

The Hygeia way is clean, quick, easy. It does away with adhesive tape, labels, tags and other make-shifts. Hundreds of hospitals have adopted it, and have found it saves time and trouble—and cuts down chances of error.



This rubber cover is used to "cork" the food-cell until feeding time arrives.

The Hygeia Breast-Nipple is shaped like the mother's breast. Babies take it readily. Used with the Hygeia Food-Cell, it is non-collapsible.

All you can use—FREE

To any hospital handling maternity cases we will send absolutely free and without obligation, as many of these 4-ounce hospital nursers as requested.

The sole condition we make is that they are to be used in the hospital—not redistributed.

By the term "nursur" we mean the complete outfit—food-cell, breast-nipple and rubber cover.

Use the coupon. We pay transportation charges.

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Send us prepaid.....4-oz. Hospital
Hygeia Nursers, as per your offer. No
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Hospital

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St. Lawrence Hospital, Lansing, Mich., equipped with two Kohler Electric Plants for emergency use

Keep electricity on hand for emergencies

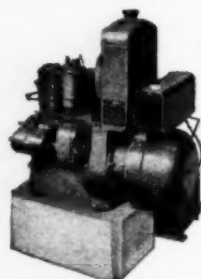
A wise and practical precaution—to have a reserve supply of electricity always on hand against failure of the regular current.

A good many hospitals have taken this precaution, by installing Kohler Electric Plants as auxiliaries. When the regular current stops, the Kohler Electric Plant starts automatically to supply current for selected emergency outlets—operating rooms, elevators serving these rooms, and other vital points.

Kohler Electric Plants have the dependability demanded by the heavy responsibilities of this service. That is shown by the fact that they have been chosen, not only by hospitals, but also by ships for emergency wireless, by the Air Mail for beacons and by theatres and other institutions for auxiliary light or power.

Kohler Electric Plants are made in 1½, 2, 5, and 10 K.W. capacities. They have no storage batteries, needing only a small automobile-type starting battery for automatic operation. They are easily maintained without expert attention.

Write for detailed information about these plants; also about fine Kohler Plumbing Fixtures in enameled and vitreous china ware.



Kohler Electric Plant
Model D-1½ K.W.
110 Volt D. C.

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ALSO MANUFACTURERS OF KOHLER PLUMBING FIXTURES

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Electric Plants

Automatic—110 Volt D. C.—No Storage Batteries

town section of the city, and radiating from it are about twenty miles of equivalent four-inch pipe. There are three 1,100-horse power boilers, using pulverized fuel. These boilers are capable of generating 380,000 pounds of steam per hour, and the increased heating load made it necessary to install the third boiler during the summer of 1927. This plant is built in such a way that an addition may be made to the building and more boilers added, which will provide ample capacity for some time to come.

After two years of operation this line has proved very successful. This is borne out by some interesting figures taken from tests on line loss of efficiency, which are as follows:

Pressure at station No. 8 (Steam Plant).....	.....
.....	.....165 lbs. sq. in. gauge
Pressure at end of 6" line 1,500 ft. from station.....	.....
.....	.....145 lbs. sq. in. gauge
Pressure at hospital 3,800 ft. from station.....	.....
.....	.....100 lbs. sq. in. gauge
Temperature steam at station.....	.....470° F.
Temperature steam at end of 6" line.....	.....420° F.
Temperature steam at hospital.....	.....360° F.
Efficiency of 6" line compared with bare pipe in still air (Impractical to test efficiency of 4" line account service connections).....	.....90.1%
Line loss average for heating season.....	.....8% of flow
Line loss for January and February.....	.....3.37% of flow
Line conductivity per square foot pipe surface per degree difference in temperature between steam and ground .....	.....15 B.t.u. per hr.

The hospital is charged with the steam supplied, as indicated by the flow meter at the hospital end of the line. The consumption during the heating season is about 6,500 pounds per hour, and considerably less during the summer. Actually the total steam required by the hospital per year amounts to 21,500,000 pounds, which is about 8 per cent less than the amount estimated for cost purposes, and represents a further considerable saving for the hospital.

Due to the fact that this is a high pressure line, the details of its construction were carefully checked and watched, the pipe was tested to 700 pounds hydrostatic pressure, and an impact test given each weld. These welds were of the electric arc type and were carefully made. Up to the present time the hospital has experienced no trouble, and the line has been referred to as a reliable and dependable branch of steam service.

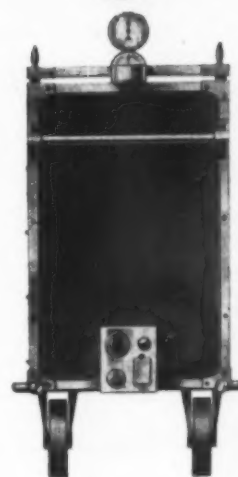
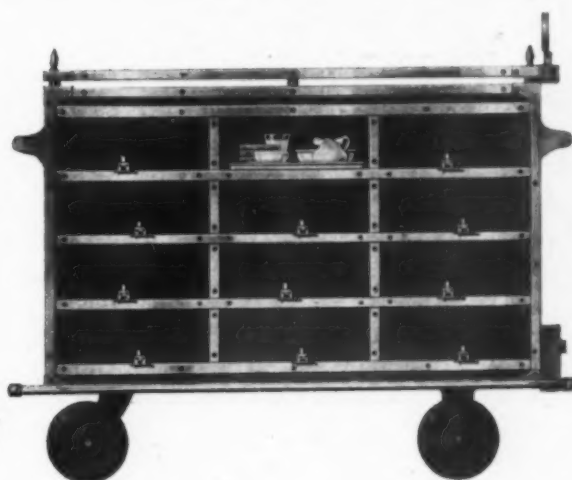
Fireproof Paneling Developed in Asbestos Product

A new fireproof panel, developed from a combination of cement and asbestos, which presents a perfect resemblance to wood paneling, or which can be given the appearance of metals, such as gold, silver, or bronze, has recently been perfected. The new product is strong, durable, easily handled, and can be applied over wood, plaster, cement or brick walls. It has certain advantages over the old style of paneling, in that it will neither split, warp nor chip. It is installed and finished in the same manner, with the same labor, and with the same materials required for ordinary wood paneling.

Wood paneling of the better type is today limited in its use by high cost, due to the fact that the fine craftsmanship necessary for producing satisfactory results is expensive. This is particularly true of wood paneling with

Complete Centralized Kitchen Service Made Possible by The Thermo-Serve-Mobile

A food conveyor serving individual trays directly from main kitchen to patient. All compartments uniformly heated by circulating hot water—not by tank enclosed moderately heated water. Humidifying system assures moist food as well as hot.



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1. Reduces cost. No expensively equipped floor diet kitchens. Less personnel necessary.
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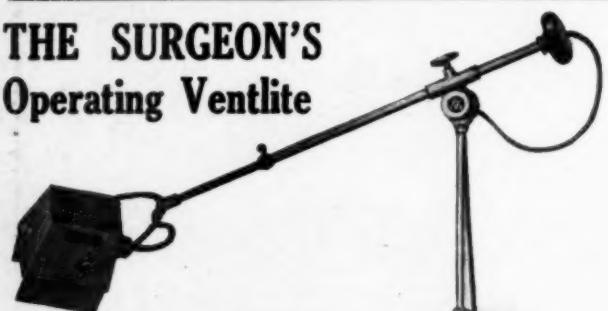
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It is instantly adjusted for any operation; no installation expense.

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more or less elaborate details. Thus a situation has been developed in this country which attaches great interest on the part of architects and owners to the announcement of a new material that possesses all of the qualities of fine woodwork, but is available in authentic designs at reasonable costs.

This paneling is provided in designs from the following periods of architecture: Gothic, Elizabethan, Tudor, Jacobean, Stewart, Norman and Breton. There are also original designs that carry the combined influences of these different styles.

In the manufacture of these panels, care has been taken to provide for the slight irregularities in construction of a room, so that when the paneling has been installed a well balanced appearance will be preserved.

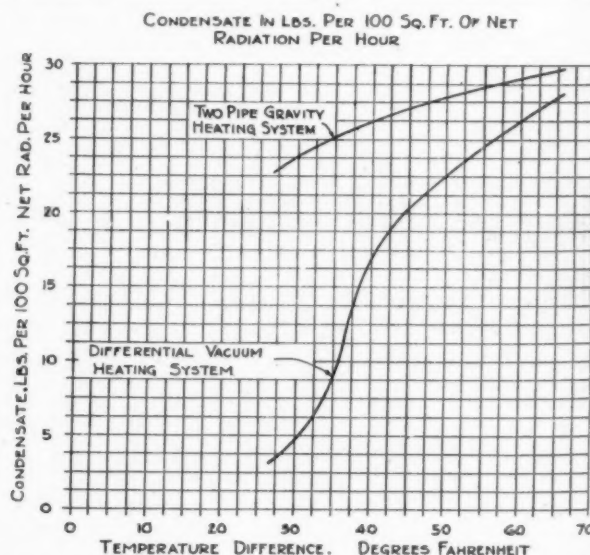
Modern Hospital Heating

Perhaps there is nothing that contributes so largely to the comfort of the inmates of a modern hospital as an efficient heating system. Within the past year there has been developed a method for circulating steam at subatmosphere pressure, which seems noteworthy.

The purpose of this development is threefold: to provide heat input in proportion to the heat loss from a room or building; to minimize the so-called drying out of the air heated, and, finally, to save fuel.

This method circulates rarefied steam, through radiators ranging in temperature from 133 degrees upwards, in direct proportion to the weather conditions that are prevailing.

In mild weather when only half as many heating units are required to take off the unpleasant chill, steam is circulated through the radiators under twenty-five inches of vacuum, and as the weather gets colder, the rarefied



condition of steam is made less, resulting in more heat being given off per square foot of radiation. It is a simple matter to balance the heat input with the heat loss, under any and all conditions, at or near the boiler-supplying the heat.

A restricted steam supply and means of creating and maintaining a higher vacuum in the return pipe than that which exists in the radiator will insure movement of the rarefied steam to all parts of each radiator, quickly and noiselessly.

The slightly added cost for such a system of heating is said to be quickly absorbed in the reduced amount of fuel

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Copper-Free No Verdigris

NO COATING TO CHIP OFF

NO PLATING TO PEEL

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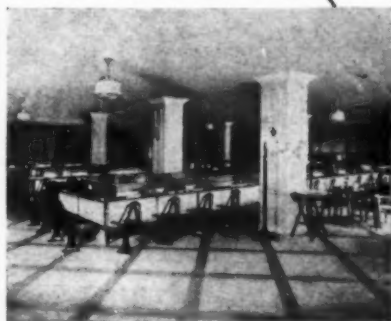
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DETROIT

Monday, December 18, 1927.

Mr. L. T. Hostetler,
Allegheny Steel Corporation,
Brackenridge, Penna.

My dear Mr. Hostetler:-

Weber & Seiber, Equipment Engineers of Chicago, have asked us to write you our reaction to Allegheny Metal.

Candidly, we took Mr. Weber's recommendation regarding this metal, but since we have found that it has fulfilled everything that we promised it would, we feel it is our duty to write you our opinion. The important item is that very little cleaning is required to keep the metal in its original lustrous condition, and it seems to be very rigid and tense, and built to withstand hard usage, and does not readily show scratches.

It was solely on account of our favorable opinion of this metal that we decided to use it in the construction of the equipment in the Detroit-Leland Hotel and also our hotel at Sedgeland, North Carolina.

Yours very truly,
H. C. CHITTENDEN, Jr.,
Manager

**EASILY KEPT
SPOTLESSLY CLEAN**

Your Ideal Kitchen Is Now Available

SHEETS PLATES BARS BILLETS TUBES RIVETS BOLTS

WAREHOUSE STOCKS—JOS. T. RYERSON & SON, INC.

Chicago Cleveland Milwaukee St. Louis Cincinnati Detroit Buffalo Boston Jersey City

ALLEGHENY STEEL COMPANY
General Offices and Works:
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New York • Chicago • Detroit • Milwaukee • Los Angeles

Allegheny

Sheets for Automobile Bodies • Metallic Furniture • Deep Draws • Allegheny Metal • Ascoloy • Electrical Sheets • Steel Castings • Boiler Tubes • Pipe



These crisp, nut-brown flakes furnish effective bulk

Physicians and nurses find Post's Bran Flakes a dependable ally in diets where bulk is desirable as a corrective of constipation.

This bulk cereal is all the more valuable in that patients relish its crisp, delicious flakes even when the appetite is most bored.

In addition to supplying natural bulk in appetizing form, Post's Bran Flakes yields such essential food elements as iron, phosphorus, proteins, carbohydrates and vitamin-B.

Postum Company, Inc.
Dept. B-2968, Battle Creek, Michigan

We shall be glad to send to any physician or nurse a sample of Post's Bran Flakes and samples of other Post Health Products, which include Post's Bran Chocolate, Grape-Nuts, Post Toasties and Instant Postum. If you live in Canada, address Canadian Postum Company, Ltd., 812 Metropolitan Building, Toronto 2, Ontario.

POST'S BRAN FLAKES

WITH OTHER PARTS OF WHEAT

as an ounce of prevention



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used, for it will be apparent that if rooms are not overheated, necessary means of dissipating surplus heat will not be required.

The accompanying chart shows heat loss with the average heating system as compared with the wide range of adjustment that would be necessary under subatmosphere heating.

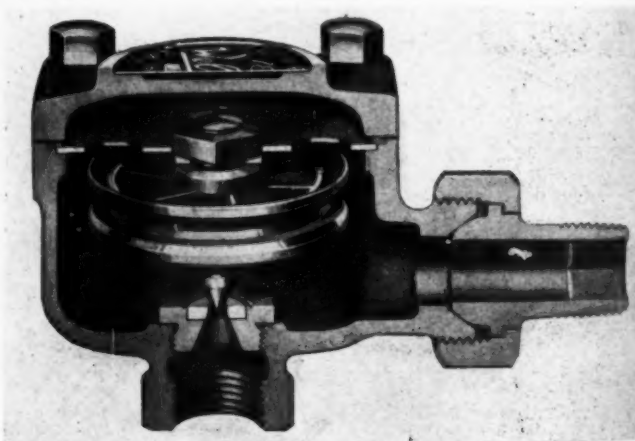
From the hygienic standpoint it has been proved that the average steam radiator, with its temperatures varying from 212 to 220 degrees F. overexpands air rapidly, causing the percentage of moisture per volume of air to decrease. The new method, it is claimed, more nearly preserves proper humidity.

Overheated radiators are said to increase the number of particles of foreign matter suspensible by the air. The radiators used in this plan, working at lower temperatures, will keep the suspended foreign particles at a minimum.

Thermostatic Traps

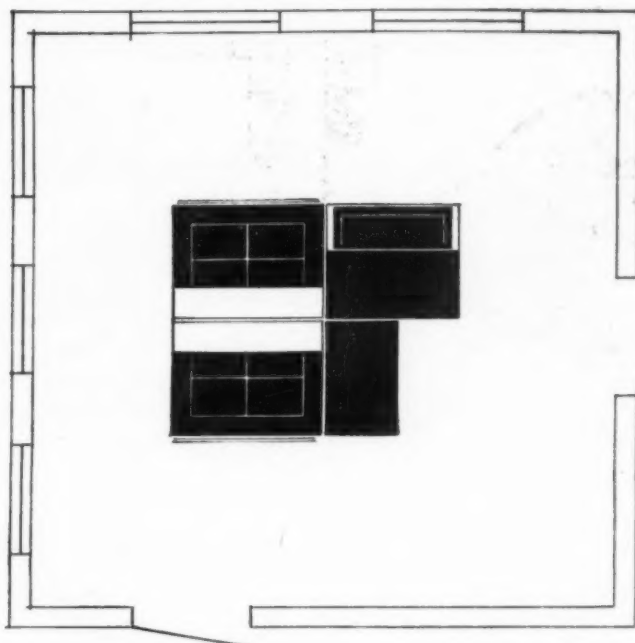
A thermostatic trap for use in connection with "process steam" pressures has been recently introduced to the architectural and hospital fields. This trap has special application to pressures used for sterilizers in hospitals. It is primarily intended for steam pressure above ten pounds but will work equally well at low pressures, although of course the capacity will decrease with the pressure.

All materials entering into the trap have been selected on the ground of their ability to withstand the severe service involved in handling steam at pressures up to 100 pounds per square inch. The body and cover of the trap



are made of steam brass. The cover is fastened to the body by four monel metal tap bolts with hexagon heads, and there is a special copper-asbestos gasket fitting into a recess, insuring a tight joint.

The expansion member is made of monel metal heavily ribbed. It is held securely in position in the trap body by means of a heavy gauge brass circular plate to which it is bolted, and which rests in a recess turned in the body. A distance nut keeps the upper part of the diaphragm far enough away from the plate to permit steam to entirely surround the diaphragm. This construction also allows the interior to be easily removed for blowing scale, sand or grease out of the piping when first started up and for later inspection and renewal of parts. The accompanying illustration shows a cross section of the device.



All the cooking equipment in a $6\frac{1}{2} \times 7\frac{1}{4}$ space

Hospital kitchen floor space is valuable. Save it by careful selection and thoughtful arrangement of the cooking equipment.

For the ranges—use Westinghouse Electric Ranges. They are floor space savers, for every square foot of the top plate is cooking surface. The heating elements distribute the heat over the entire area. There are no spots too cool for cooking. Thus the Westinghouse range has a greater capacity than a fuel-fired range of the same dimensions. Two electric ranges will do the work of three fuel-burning units.

For the broiler and the auxiliary units—such as a griddle—use Westinghouse electric equipment. They can be placed alongside of the ranges without an inch of waste space.

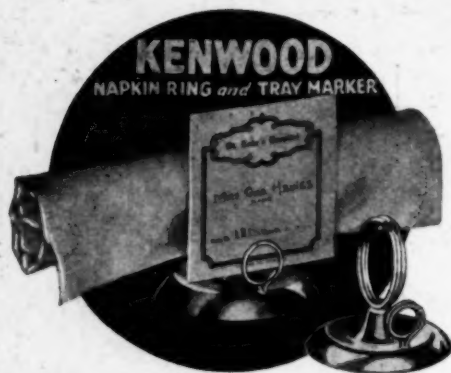
And with the advantages of greater capacity and flexible arrangement, Westinghouse electric cooking equipment offers low cost operation, great cleanliness and long life.

The new Catalog 280 gives complete information on all Westinghouse electric cooking equipment. Have you received your copy?

WESTINGHOUSE ELECTRIC & MANUFACTURING COMPANY
COMMERCIAL COOKING SECTION / MANSFIELD WORKS / MANSFIELD, OHIO

Westinghouse





DISTINCTIVE

A dignified, efficient and distinctive method of marking hospital trays which appeals to the patient's sense of individuality and gives evidence that the institution is using care in keeping every patient's tray and napkin properly identified. It occupies but small space, fitting into the corner of the tray. It provides ample ring space with separate clip for the card. Holder is silver plated on hard white metal; very durable. Cards are specially printed with the name of your institution. Can be supplied in colors for special diets, if desired.

- 141-A-3—Silver holders, per doz....\$5.50
- 141-A-4—Specially printed cards, white only, per 1,000.....\$3.00
- Additional thousands 2.25
- 141-A-5—Specially printed cards, any color or assorted, per 1,000.....\$3.50

The above is a typical example of the many items in hospital service which have been designed by us to improve or economize hospital service.

Will Ross, Inc., offers a complete service in hospital supply, furnishing virtually everything but foods and drugs. If you are not using our catalogue regularly both of us are losing much. May we send you a copy?

A cellulose absorbent that has set new standards of quality, that has brought prices down, and is favored by hospitals because of the convenient way it is packed and the ease with which it can be handled and used. Cheaper, more absorbent and convenient than the best absorbent cotton. Supplied in two, five and sixteen pound rolls or in cut size. Prices on application.

Sanisorb

THE IDEAL ABSORBENT

WILL ROSS, INC.

WHOLESALE HOSPITAL SUPPLIES

459 E. WATER ST. MILWAUKEE

Book Reviews and Current Hospital Literature

Michigan Handbook on Hospital Law

By DOROTHY KETCHAM, Ann Arbor, Mich. Prepared in Cooperation with the Michigan Hospital Association.

For several years Miss Ketcham and a committee from the Michigan Hospital Association, consisting of the late Father M. P. Bourke, Dr. Stewart Hamilton, superintendent, Harper Hospital, Detroit; Dr. W. L. Quennell, superintendent, Highland Park General Hospital, Highland Park, and Robert G. Greve, University of Michigan Hospital, Ann Arbor, have been working on the compilation of laws affecting the hospitals in the state of Michigan. The volume was presented at the last meeting of the Michigan Hospital Association, held in Detroit, April 19 and 20.

The object of the handbook is to inform superintendents regarding laws, either national or state, that in any way govern the conduct of the hospital. It is complete as now published. Nothing has been overlooked and all of it is written in language perfectly clear to laymen as well as lawyers.

The association is selling the book to members for \$1.50 and to others for \$2, and in this way it is hoped to cover the expense of printing. It is worth the investment for all superintendents, but particularly for those in the state of Michigan. It may be obtained from Robert G. Greve, University of Michigan Hospital, Ann Harbor, Mich.

The Foundations of Nutrition

By MARY SWARTZ ROSE, Ph.D., Professor of Nutrition, Teachers College, Columbia University.¹

The subject of nutrition has been thoroughly covered in Dr. Rose's book, beginning with the early history of its study, continuing through to the most recent discoveries and finishing with a chapter on the planning of an adequate diet. In her preface to this study Dr. Rose compares the human machine to an automobile and points out that our eating habits often resemble the running of an automobile with only the knowledge of what must be done to make it go but with little idea of the inner mechanism. Her book explains in detail the results of our eating habits.

Each chapter is subdivided and the various divisions of each subject are dealt with separately. Some of the subjects are the body's need for energy and the source of supply, the energy requirement of adults, the energy requirement of children, the shortage and surplus of calories, the body's need for building material and food as the source of supply.

The book is well illustrated with charts and diagrams, and is an excellent reference book on nutrition.

¹ The Macmillan Company, New York, 1927.

EASY TO KEEP CLEAN. No fuss or fancy work, no unnecessary outside rods or levers. The simplest design possible to assure trouble-free and continuous action. No finer or more practical piece of soap service equipment has ever been offered hospitals. Pure white enamel and glass and the working parts made from non-corrosive metals.

LOHADOR

Foot Pedal *Liquid Soap*

DISPENSER

has won instant approval from all who have tried it.

A large capacity bowl which does not need such frequent refilling is a time saver.

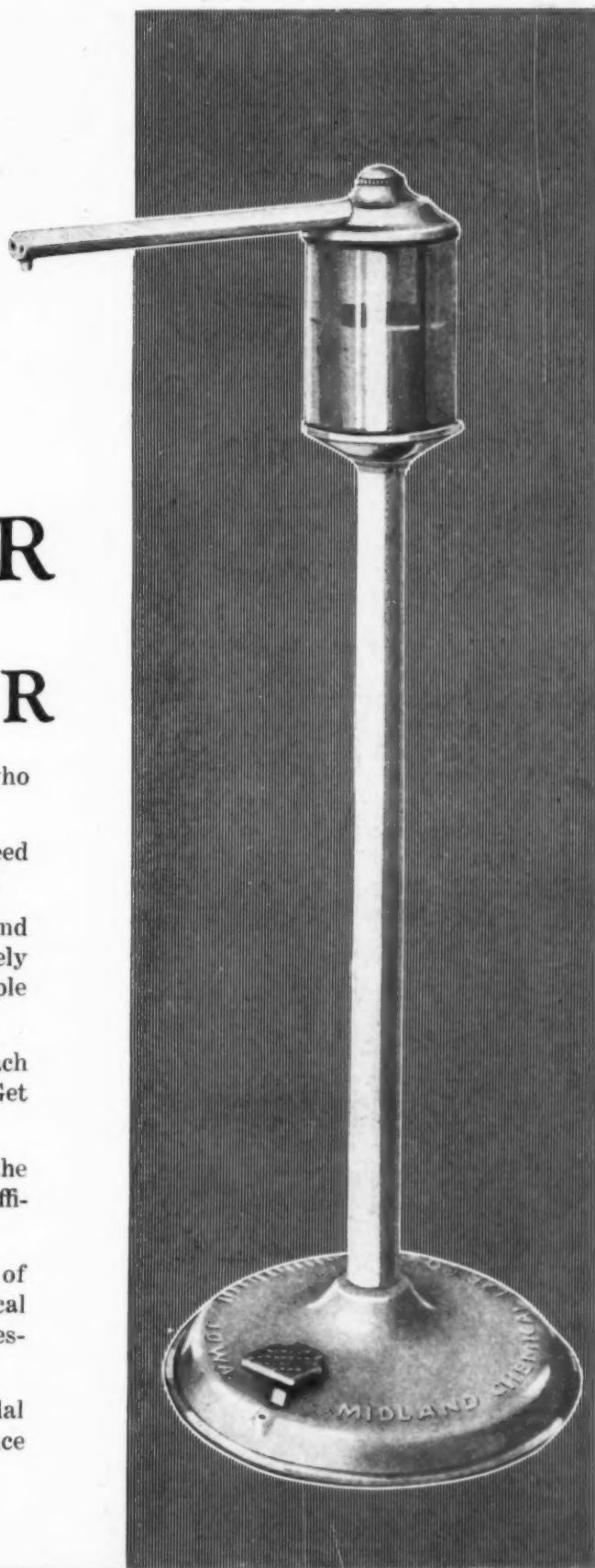
The swivel action of the bowl on the stand permits the bowl to swing completely around. It serves a number of people conveniently and quickly.

The quantity of soap obtained at each stroke of the pedal may be regulated. Get it drop by drop or in a tiny stream.

Heavy enough to be absolutely firm on the floor yet not so bulky that it is a difficult task to move it.

Long known for the high quality of their hospital products, Midland Chemical Laboratories, now offer the finest accessory for the use of liquid soap.

A trial of the LOHADOR Foot Pedal Liquid Soap DISPENSER will convince you of its worth.



MIDLAND CHEMICAL LABORATORIES, INC.
DUBUQUE, IOWA, U. S. A.



End Hospital Laundry Problems

Palmolive Products Solve an Old Difficulty

OPERATING your own laundry brings up many annoying problems. Let us aid you in eliminating these.

Many years of research devoted to laundry work has given us a thorough knowledge of laundry details. Our laundry soaps are made to meet every condition of a laundry, large or small.

Hundreds of hospitals now find in our soaps, the answer to their needs. Work is better—running cost less. Reports are enthusiastic.

Just read what we have done for you. Our 66 year old reputation stands back of every claim.

Woolens Soft and Fluffy, No Shrinkage

Badger Flakes—88% all soap, titre 42°. They dissolve quickly—can be used direct in the wheel. They are specially suited for continued work under high temperatures.

Badger Kwiksolv—the same high grade soap in the form of mealy grains. Instantly soluble and produce 100% efficient lasting suds for high temperature work.

Texolive Kwiksolv—pure olive oil base. 92% plus all-soap titre 22°. Dissolves instantly in water of any temperature. Will not harm any fabric water itself will not harm. Ideal for linens, blankets, etc.

A Trial—Please

Decide which of the above is best suited to your requirements. Then order a trial barrel. Make any test. Its performance will stand back of any claim. Write today.

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Broadcast every Friday night—from 10 to 11 p. m., Eastern time; 9 to 10 p. m., Central Time — over Station W E A F and 31 stations associated with The National Broadcasting Company.

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KANSAS CITY MILWAUKEE BERKELEY
Makers of Texolive Kwiksolv, Badger Flakes and Kwiksolv, Pearl Chips and Granulated, Crystal Neutral and Granulated.

8991



NEWS OF THE HOSPITALS

California

Ground was broken a short time ago for the construction of a \$100,000 hospital in Fresno. Charles Brown, formerly of the Southern California State Hospital, Patton, will be in charge. One of the interesting features of the new building will be the introduction of a periscopic arrangement whereby attendants will be able to look into the patient's room without the knowledge of the patient.

Announcement has been made of the opening of a new building at the Eye and Ear Hospital of Los Angeles, Los Angeles. The building is arranged with a view to the future so that additions may be added if necessary. Dr. Louis Kemp and Dr. Simon Jesberg are in charge of the institution.

Colorado

A graduate course in neuropsychiatry will be given by the staff of the Colorado School of Medicine, Boulder, this summer. Only doctors of medicine are eligible, and the fee for the course will be \$100.

Connecticut

Evidence of the anticipation of the Bridgeport Hospital, Bridgeport, as a medical center, is shown in the completeness of the equipment that is being provided in the addition now being built. The new building, which will provide eighty-seven new beds, will have a solarium on the roof, each floor will be equipped with an x-ray machine which may be used at the bedside. Each floor is to have a treatment room where surgical dressings will be applied instead of at the bedside, and a number of the rooms will be soundproof. The decorations will not be along the old lines of solid coloring, but will be in soft subdued shades of grays and greens. All modern facilities, and opportunities for research and investigative work will be provided, so that the doctors, it is hoped, will accept this as the center for their activities. The addition will be three stories in height and the cost of construction will be about \$300,000.

District of Columbia

As a memorial to his wife, former representative John Dalzell left \$10,000 to the Homeopathic Hospital, Washington.

Florida

The opening of the Monroe Memorial Hospital, Ocala, has recently been announced. The hospital is of fireproof construction and has a capacity of sixty-six beds.

Illinois

The new Woodlawn Hospital, Chicago, has recently been completed and will be opened early in the summer. The building is a six-story fireproof construction with all modern facilities and a capacity for 145 patients.

The Wesley Memorial Hospital, Chicago, has recently

Announcing!

An Achievement in Small Dish Washing Machines



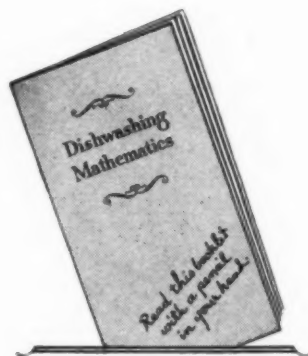
ODEL "O" is the latest addition to the Champion line. That it ably meets the demand for a practical, low-priced, small Dish Washer is evident from the following partial list of its features:

1. PRICE: \$290—lowest priced Dish Washer on the market.
2. SIZE: requires minimum floor space—table level height—no superstructure.
3. LOCATION: may be set anywhere, flush in corner if desired, as it feeds from the top.
4. OPERATION: simplest—controlled by *one lever only*.
5. CONSTRUCTION: extremely simple yet sturdy; made entirely of cast iron, except lid, which is cast aluminum.
6. STERILIZATION: steam sprays *above* water level rather than mixing steam with washing water.
7. RINSE SPRAY: solid spray rather than the usual hollow, conical spray.
8. ADAPTABILITY: when not in operation it can be used as a sink.
9. FINISH: gray Duco enamel—attractive finish that does not soil easily.
10. MOTOR: sets in niche beneath machine—absolute protection.

Send for particulars regarding this triumph in Dish Washing machines.

CHAMPION DISH WASHING MACHINE COMPANY
HOBOKEN, NEW JERSEY

1358 Builders Bldg., Chicago



Institutional Managers may receive a copy of "Dishwashing Mathematics" upon request. This book contains simple formula for determining the washing costs of your tableware.

Built like a Battleship!



CHAMPION

Dish Washing Machines

A common-sense and natural relief

KELLOGG'S ALL-BRAN relieves and prevents constipation by promoting natural, healthful elimination. Nature calls for just the bulk or roughage that ALL-BRAN supplies.

Laxatives can at best afford only temporary relief. They frequently lend themselves to harmful misuse.

ALL-BRAN is 100% bran, depended upon and recommended by many physicians. Only an all-bran product can accomplish complete results.

A delightful cereal that makes a "pleasing prescription." Serve with milk or cream, with fruits or honey added, sprinkled on other cereals, in soups, or use in many forms of cooking.

Made by Kellogg in Battle Creek, Michigan. Sold by all grocers. Served everywhere.

Kellogg's
ALL-BRAN



purchased the medical school property of Northwestern University, which adjoins the hospital property. It is understood that the Wesley Hospital will remain on the south side.

The will of the late Mrs. Pheobe Seipp, Chicago, provided for a bequest of \$15,000 to the Grant Hospital, Chicago.

Indiana

During the first four months of operation of the William H. Coleman Hospital for Women, Indianapolis, new unit of the Indiana University School of Medicine, 180 babies were born in the hospital. The institution has a bed capacity of sixty-five, divided between obstetrics and gynecology. There were 628 admissions and 205 patients were enrolled in the out-patient department, which is chiefly devoted to prenatal care and follow-up of post-operative cases.

Iowa

The bed capacity of the Osceola Hospital, Sibley, has been doubled by the opening of a new wing which was recently completed. The new building is of modern construction and has up-to-date equipment, having a refrigerating system, a complete x-ray physiotherapy laboratory and most of the modern conveniences found in the larger hospitals.

Maryland

It is reported that fire almost completely destroyed the Emergency Hospital, Annapolis. All the patients were safely removed from the building.

Plans are completed and arrangements are being made to break ground for a new seventy-five bed addition to the Shephard and Enoch Pratt Hospital, Towson. The new building will be used as a reception hospital and diagnostic clinic and will raise the capacity of the hospital to 220 beds. Dr. Ross M. Chapman is superintendent.

By the will of Mrs. Rebecca Lanier King, Baltimore, the Johns Hopkins University is to receive \$50,000, the Johns Hopkins Hospital \$105,000, the Presbyterian Eye, Ear and Throat Charity Hospital, \$5,000 and St. Joseph's Hospital \$2,500. These hospitals are all in Baltimore.

Massachusetts

A pay consultation clinic has been started at the Massachusetts General Hospital, Boston, to which patients are admitted by appointment only, and through the recommendation of a regular physician. In his letter of recommendation, the physician states the nature of the patient's complaint and the special examination desired. This is expected to do away with much of the imposition upon hospitals by some physicians who have the habit of referring pay patients to a free clinic.

New Mexico

A new hospital, a branch of St. Mary's Hospital, Chicago, is being built in Clayton. It will have a capacity of forty beds and will be operated jointly with the old Clayton Hospital.

New York

The Brooklyn Hospital and the Sunshine Branch for the Blind have received \$10,000 each, and the Industrial Home for the Blind and the House of St. Giles the Cripple, all of Brooklyn, have received \$5,000 each, in fulfillment of the terms of the will of Mrs. Annie M. Pluygers, widow of the former consul general of the Netherlands.

The case management may call for a carbonated beverage. If so, prescribe "Canada Dry"



Don't accept
substitutes
or imitations

© 1928

NO ginger ale could be more popular in the sick-room. "Canada Dry" has a mild, mellow flavor . . . a subtle gingery taste . . . that quickens lagging appetites and provides a welcome change of regimen for the patient.

You can safely prescribe "Canada Dry" because it is as pure as we can make it. The ingredients are of the finest quality. They are blended and balanced with skill. Exact proportions prevail throughout and constant watchfulness prevents any variation from those proportions.

"Canada Dry" contains pure Jamaica ginger of the finest quality as well as other absolutely pure ingredients. A secret method of carbonation insures uniformity of charging and enables "Canada Dry" to retain its sparkle long after the bottle is opened.

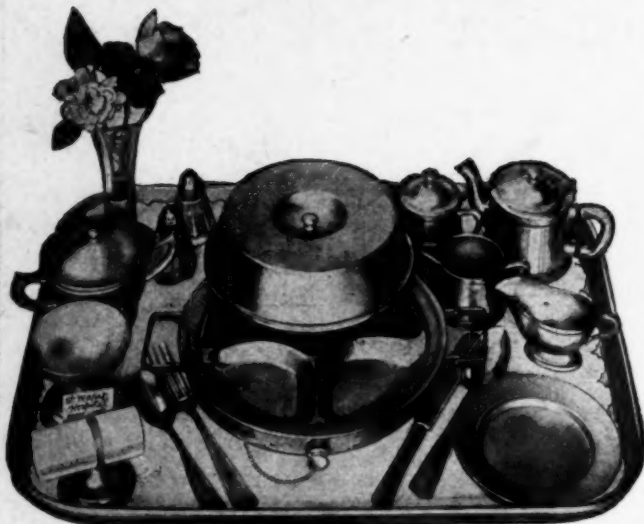
There is no capsicum (red pepper) in "Canada Dry." Therefore, it does not bite the tongue or leave an unpleasant after-effect. Leading hospitals serve it. Leading physicians often prescribe it. This pure carbonated beverage is very palatable to patients.

"CANADA DRY"

The Champagne of Ginger Ales

Extract imported from Canada and bottled in the U. S. A. by Canada Dry Ginger Ale, Incorporated, 25 W. 43rd St., New York, N. Y.
In Canada, J. J. McLaughlin, Limited. Established 1890.

THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Plate Flatware.

THORNER BROTHERS

*Importers and Manufacturers of
Hospital and Surgical Supplies*

135 Fifth Avenue
NEW YORK CITY

Catholic Hospital Assn. Exhibit, Cincinnati Music Hall, Cincinnati, Ohio. June 18th to 22nd. Booth No. 43.

The Trinity Hospital, Brooklyn, has recently opened its doors to the public. The building was formerly used by the late William F. Campbel as a private institution. It is a fireproof structure of Spanish architecture, having a bed capacity for eighty-five patients.

Inwood House, New York, a free place of treatment for the consumptive poor, which was housing eighty-five tuberculous patients, was closed April 1. The closing of the institution was a result of an order from the city which declared the building to be a fire hazard, as there has recently been a shortage of water and the building is an all wood structure. William M. Cruikshank, treasurer of the hospital said that plans were being made for the construction of a new building which it is hoped will be ready within a year.

Pennsylvania

The erection of a maternity building at the General Hospital, Lancaster, started in May. The new building will add fifty beds, swelling the total capacity to 235 beds. The structure which will cost about \$325,000, will be erected on the site of the present nurses' home.

Tennessee

Remodeling of the Crook Sanatorium, Jackson, has been completed, and the institution is now equipped to handle ninety-five patients. One of the features of the hospital is that it has a department, complete in itself, for handling colored patients. All modern furnishings and the newest facilities in hospital equipment have been provided.

Washington

Plans for enlarging the Virginia Mason Hospital, Seattle, were complete and work was begun about the first of April. The present building has 100 beds, and the proposed addition will add 120 beds, making it one of the largest hospitals in the city.

The new seventy-five bed H. A. Compton Pavilion of the St. Joseph's Hospital, Bellingham, has been opened lately.

Canada

A new nurses' home at St. Boniface Hospital, Manitoba, has recently been opened. The old nurses' quarters have been refurnished and this has made it possible to add 100 beds to the capacity of the hospital. Of the 100 new beds, thirty are to be used for maternity cases.

Completion of a \$175,000 addition to the Providence Hospital, Moose Jaw, Sask., has recently been announced. The new building is four stories high and of fireproof construction. It is one of the most modern hospitals in western Canada. It is already occupied, but the formal opening will not take place until May.

Another addition to the Victoria Hospital, London, Ont., is to be started in the near future. The building will cost about \$65,000 and will raise the capacity of the new buildings to 210 beds. When this addition is completed it will be possible to vacate the old building.

Foreign

A building program, the execution of which will cost about \$900,000, has been planned for the South London Hospital for Women, London, England. The new buildings will be used for nurses' quarters, and hospital accommodations. It is planned to increase the capacity by 200 beds.

Construction of a new \$500,000 addition to the Kent and Canterbury Hospital, South Canterbury, England, will soon be started. The original hospital was built in 1793.

